State of Maryland / Department of Health and Mental Hygien 2001 34501 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Bernard J. Emard /Medical October 23,2004 5:10 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Copper Ridge Nursing Home Sykesville Carroll 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months **X**XM 2□ F Days Director Yrs. 336-18-0929 87 Feb. 23, 1917 Illinois Usual Residence of Decedent with the Maryland Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Neulcal Examinat must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Carroll Sykesville Director 1 ☐ Yes 🔀 🛚 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Obrecht Road 21784 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes XX No XXWidowed 4 Divorced Specify: Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other trainmetin. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer Communications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Emard Helen Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Greenwald/daughter 691 River Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial XXCremation 3 ☐ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) National Cremetory oct.27, 2004 Falls Church, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Witzke Fureral Homes, Inc.
5555 Twin Knolls Road, Columbia, MD 1/elma 21045 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical one neek Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 4☐Pregnant at time of death Month Year P.O. | 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by Division of Vital Records, 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 24a. Was an autopsy 2 No 1 Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No 1 Inpatient Other: 1 Yes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ☐ Other (Specify) this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 Accident investigation М 2 No filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital to certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely lhe 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059943 October 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John C. Arbel, M.D. 295 307 Westminster Mis. 31. Date filed Mith, Pay Year 13 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			For 1 = State Registrar		State	of Marylar	nd / Dep <i>Ce</i>	artment ortificate	of H	lealth a	and M	lental Hyg	giene Reg. No.	2004	34502
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la la	D 2 2 7	To B	Richard J.	Sch	ulz					Co	rdeli	la S	toke	s	
ary	운 D E E	_	19a. Informant's Name/Reia	tionship (Type, Print)		19b. Mail	ing Address (5	Street a	and Numb	er or Rura	al Route Numbe	r, City or	Town, State, Zi	p Code)
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier 1 Certifier (Check only one)	tifying P dical Exa	miner: On the	ne best of my kn basis of examin nner stated.	owledge, dea ation and/or i	th occurred at nvestigation, ir	the tim	ne, date ar pinion, dea	nd place, ath occurr	and due to the ded at the time, of	ause(s) a date and p	nd manner as s lace, and due t	stated. to the cause(s)
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	Physici /Medic			0.	Fuhrman,	Sr.		2. Date of Dea Month October	Day 28,	Year 2004	3. Time of Death 7:00 p
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	Director		189-07-0215 Usual Residence of Decedent	11∑M 2□F {	38 Yrs.	Months Days	Hours Min.	8. Date of Birtl (Month, Day Feb 23	, Year) 1916	Peni	nsylvania
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215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Hems 23e or 28e-f show event, the Medical Examinar must be motified at	ted by Funeral Director	5205 Feese: 11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent Amed Forces? 1 □ Yes 2 1 If Yes, Give Year or Dates:	No 16a. Dece	Was Decedent of H If Yes, specify Cuba 1 Yes 2 X No	ispanic Origin? (Sp n, Mexican, Puerto Specify:		14. F B	J. S. A. ace - America fack, White, e cify: W Business/Ind	hite
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_	To the Hospital or Attanding within 24 hours after death. To the Funaral Diractor: After completely filled in by the fune	Medical Co	29a. Certifier (Check only one) Certifying Medical E	3 Physician: To the best examiner: On the basis of and manner st	of examination and/or in	h occurred at the time vestigation, in my of 29c. License	pinion, death occur	red at the time, o	late and plac	manner as sta e, and due to ned (Month, D	the cause(s)
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				Amend item #11, per 1-State Registrar	State of Mar		artment of I			ene2004	34504
		Physicia	an	Decedent's Name (First, Middle, La Oliver	R.	Fo	lder		2. Date of Death Month 10 28	Day Year	3. Time of Death
	>	/Medic Examin	al	4a. Facility Name (If not institution, giver 700 Mello Ct.		16		or Location of Death	10 28	4c. County of Deal	6:35a M
		Funeral Director		5. Social Security Number 6. S 218-60-6009	ex 7. Age (/ X IM 2□ F 4	in yrs. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Oay, 2-10-55		hplace (State or Foreign untry) Md .
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	Mary Ind 2 shou	Ith and M 27 is mar r treumat	_	19a. Informant's Name/Relationship (Victoria C. Whit			•	t and Number or Rura		City or Town, State, 2	Tip Code) 217
	more,	ant of Health at: If Item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	20b. Place of Dispo cemetery, cren Greenmou	natory or other pla	100)		Oc. Location - City or Baltimore	
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•		1		30. Name and address of person who	complete cause of deat	h (item 23a) Type,	YWOO	ATH S	Billing	we His	2/2/8
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State Registrar 111 Penn Street, Baltimore, Maryland 21201

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Southail

31. Date filed (Month, Day, Year) NOV 0 1 2004 mo

32. Registrar's Signature

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible. Amend Item#2, 8 per FH, MD, C837, I1/9/04TI State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 34506 Certificate of Death Reg. No. 2. Date of Death 10/31/04 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** silerest. Kober 3:30A.M 01 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 8810 d , Apt. 1626 7. Age (In yrs. last birthday) 88 Yrs. HAR If Under 1 Year Blvd. If Under 24 Hrs. TMORE Walther 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Country)

H () 5. Social Security Number Date of Birth (Month, Day, Year) Days Min. Months Hours 280-12-4016 /30/16 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 1 | Yes 2 | MD Completed by Funeral Director HUT MORE 'ARKVILL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8810 34 219 pt. 162 12. Was Decedent Ev Amped Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Ever in U.S. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government. Meteorolog 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KREICH BAUM ۵ rest 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, cramatery or dither place) Hot. 1626 silchest PARKVILLE 21234 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State

4 Donation 5 Other (Specify) 20d. Location - City or Town, State Forest HII MD 11-1-0-1 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility BACH MORE ND 21234 EVANS FLIDERAL CHAPEL, 8800 HARFORD RD 23a. Part1. Enter the disease or complications that can shock, or heart failure. List only one cause on expensions that can shock or heart failure. Approximate Interval Between Onset and Death o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 213No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 1 ☐ Yes 2 100 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Hospital: 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

physician and s the burial-transit as attending use for signed by the a d be detached f P.0. þ Division of Vital Records, as been signal has page certificate Physician: funeral director, After Hospital or Attending death. within 24 hours after death To the Funeral Director: the in by 1 filled ro the

Funeral

Director

filed within 72 hours after death with the Maryland

Pages 1 and Baltimore,

permit.

Department o Important: If any injury or

Physician /Medical

Examiner

Maryland 21215-0036

it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, If a Mydical Examinating the India of

State Registrar

31. Date filed (Pal. Year) 2004 32

30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

29b. Signature and title of certifier

Registrar's Signature

29c. License number

29d. Datersigned [Month, Day, Year) 01

State of Maryland / Department of Health and Mental Hygien 2 0 0 1 34507 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** GORDON October 2004 11:08 A LARRY **JAMES** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 28538 Hudson Corner Road Marion Station Somerset 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours Min. 1⊠M 2□ F 57 Yrs. 219-46-2612 Director July 17, 1947 Pennsylvania Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23s or 28s-f show sminer want be notified at 1 ☐ Yes 21 No Director Maryland Somerset Marion Station 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 28538 Hudson Corner Road 21838 USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after or Hygiene. All Myes 2 No Vietnam If Yes, Give Year or Dates: Erra 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No by Specify: White 3 ☐ Widowed 4 ☐ Divorced Era "naturel". ine Medical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Waterman Seafood 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othen eny injury or other traumatic event pobes. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Floyd Milton Gordon Rachel Susan Ream 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly W. Gordon (Wife) 28538 Hudson Corner Road - Marion Station, MD 21838 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Paul's Cemetery October 30, 2004 Marion Station, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

**Many Seth Bradshaw-Pruitt*

22. Name and Address of Facility
Bradshaw & Sons Funeral Home

306 W. Main Street - Crisfie

23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 306 W. Main Street - Crisfield, Maryland 21817 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ASCVD **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical as the IF FEMALE esn 0 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Yeer) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation death s after death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \(\text{Homicide} within 24 hours a To the Funerel I o the Hospitei 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D48098 October 29, 2004 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 2004

Vijay Karumbunathan,

M.D. - 201 Hall Highway - Crisfield, Maryland 21517 32. Registrar's Signature

General.

State of Maryland / Department of Health and Mental Hygien 34508 Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month 7:33 PM **Physician** October 28, 2004 Fernando 0. Gonzaga /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 9117 Wandering Trail Drive Potomac ff Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1 **X**M 2 □ F 73 April 18,1931 Brazil 218-37-0986 Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehror any injury or other traumatic event, the Medical Expension of the property of t 10d. Inside City Limits 10c, City, Town or Location 10a, State 10h County 1 ☐ Yes 2 ☑ No Director Potomac Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9117 Wandering Trail Drive 20854 Brazi1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Financial Analyst International Banking 4 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Maria Dutra Anisio Gonzaga ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Araceli A. Gonzaga/Wife 9117 Wandering Trail Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition October 2004 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Montgomery 2004

Crematorium Inc.

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Rockville, Inc. 300 West Montgomery Avenue,
Rockville, Maryland 20850

Approximate 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee ZRR M01356 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final **Physician** Bilateral Pneumonia Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner B Cell Type Lymphoma 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner burial-transit and resulting in death) Last Due to (or as a consequence of): Box 68760, the attending physician the doring the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Live birth Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2☐ No be detached Division of Vital Records, P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2. ♣No ☐Yes 2☐No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 2 XNo 2 1 TYes this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? filled in by the funeral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death Certification: Injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No after death. I Diractor: Af investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 24 ho To tha Fund completely t To tha 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D29256 October 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4343 Montgomery Avenue, Suite 101, Bethesda, Maryland 20814 Jose Quiros, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar Sports? NOV 1 * 2004

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of	Maryland		artmen rtificate			and M	lental Hy	giene ()	04	34509
	Physici /Medio		1. Decedent's Name (First, Middle LIT) Ward Store		riddin	5					2. Date of De Month	Day	Year	3. Time of Death
>	Examir		4a. Facility Name (If not institution			CALL	4b. City,	Town, or	Location of	of Death		4c. Cou	inty of Death	
I	Funeral Director		5. Social Security Number 216-30-7415	6. Sex 7 1 🖾 M 2 🗆 F	. Age (In yrs. last	t birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 10-31-19	th 1 <i>y, Year)</i> 34	9. Birth Cou Mary	place (State or Foreign otry) Land
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	Town or La	ocation							10d. Inside City Limits
	Ba-f si	ector	MD	NA NA	В	altim								1 Yes 2 □ No
	with ti	Dir	10e. Street and Number 4228 Frederick Aven	m ie			10f. Zip	Code 21229				10g. Citizen		ntry?
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Heelth and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other treumetic event, it a Mudical Exprintment must be inclined at	by Funeral Director	11. Marital Status 1 Never Married 2 X Marr 3 Widowed 4 Divorced	12. Was Deced Armed Ford ned 1 1 Yes 2				ent of His	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)		Race - Ameri Black, White, acify:	
21215-0036	within 72 hou ene. then "neture the Medicul E	Completed		it's Education st grade completed)		I6a. Dece (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired)	ution luring most	t of worki	ng		f Business/In	dustry
	filed wi Hygien ther th		12 17. Father's Name (First, Middle,	2 (ast)		Home	2 Impro	vemen		r's Name	(First, Middle		ate Sect	cor
Maryland	ould be f Mental P arked of	To Be	Farl Giddins								1 Giddin		iame)	
Mary	2 should I and Meni is marker reumetic		19a. Informant's Name/Relations				_				I Route Numb		wn, State, Zij	Code)
Baltimore, I	Pages 1 and nent of Heelth int; if Item 27 iry or other tr		Joyce M. Giddins 20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal from Si	alo	e of Dispo etery, cre	osition (Nam matory or of	ne of ther place	e)		imore, M	20c. Locatio	on - City or To	
Baltin	permit. Pages Department of Importent: If it any injury or once		21. Signatura of uneral Service		1	2:	2. Name an	d Addres	s of Facilit	у	N. Gilmon	wings St. Ba	-	
	Physician /Medical Examiner		23a. Jan1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. One to (o	used the death. In the line.	Do not en	thy term	e of dying	, such as			rrest,	6	Approximate Interval Batween Onset and Death
8760,	The law requires that the death certificate be executed the hes been signed by the attending physiclen and bage 2 should be detached for use as the burial-transit	dicai Examiner	Sequentially list conditions if any, leading to immediate cause Ernst Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (o	r as a consequent	nce of):	2						6	years
P.O. Box 6	at the deeth certific by the attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	ome of pregnancy th 2 [] Fetal de nt at time of death vn	ath 3	Ectopic pro						Date of delive	ery Day Year
	w requires that been signed b should be deta	þ	Part II. Other significant condition Pialetes	ons contributing to dea	th but not resulting	ng in the u	nderlying ca	ause give	n in Part I.			obacco use co Yes 2 □ No		he cause of death? pably 4 □Unknown
Il Records,		Completed									24a. Was autor perfo 1 Tyes		prior to co death?	ppsy findings available mpletion of cause of
Vital	Physicien: Th this certificete ral director, pag	Be	25. Was case referred to medica examiner?	Hospital: > 4				. Othe	-		(Check only o			
of	ing After	ation; To	1 Yes No 27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	28a. Date of (Month,	-	Outpatier b. Time of Injury		8c. Injury Work	4 🗀 1901	2	ne 5 🗌 Residente 1			(y)
Division	i Zige	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286, Place o	f Injury - At home j, etc. <i>(Specify)</i>	, farm, st	reet, factory	, office		1	28f. Location (City or Tox		mber or Aura	al Route Number,
	To the Hospitei or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	(Check only 2 Medicel one)	ng Physician: To the b Examiner: On the bas and manne	is of examination	dge, deat and/or in	vestigation,	in my op	inion, deat	d place, a	and due to the ed at the time,	date and plac	e, and due to	the cause(s)
	To To	Σ	29b. Signature and title of certifie	Chance	u ()		290	License	number	>		29d. Date sig	ned (Month,	Day, Year)
	141		30. Name and address of person	who completed cause	of death (Item 23	Ba) (Type,	Print)	× 10	290	9		10-2	1-200	4
	571		AUGUSTIN CH	XU.M.D. 3	900 Lect	Stal	on B	ar	1. Bu	etti	nose k	19 21	2/8	
	Sta Registr		31. Date filed (Month, Day, Year)	2004	gistrar's Signature	19	100	rela						

State of Maryland / Department of Health and Mental Hygien 004 Certificate of Death

2. Date of Death Month

October 0

34510

2004

3. Time of Death

10:30 AM

1	Examin	er	4a. Fecility Name (II	i not institution, giv	e street and nu	mb o r)		40. City, 11	own, or	Location of Dea	m	40	. County C	Deam		
			College M	lanor				Luth	erv	ille		E	Balti	more	,	
	Funeral Director		5. Social Security N 218-32-06		□M 2] Ω F	7. Age (In yrs 106		y) If Under 1 Months	Year Days	If Under 24 Hrs Hours Min		orth Year 9, 1	898	9. Birth Cou Mar	place (Stantry) y Lan	ate or Foreign
	ъ		Usual Residence of													
	Marylar I show	tor	Maryland	10b. County Baltim	ore	1	ity, Town or altimo									de City Limits Yes 2∭ No
	3a or 28s	Il Direc	10e. Street and Nur 6816 Blen					10f. Zip 0	212			-	tizen of W			,
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "naturel", or items 23a or 28a-f show or other treumstic event, Ite Madical Exeminer must be mullied at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed	ied 2 Married	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2∭No ve	J.S. 1	3. Was Decede If Yes, specif	y Cubar	spanic Origin? (: n, Mexican, Pue Specity:	Specify Yes or N to Rican, etc.)	10-		c, White	ican India , etc. ite	n,
21215-0036	n 72 ho "natur	Completed	(Ѕрес	15. Decedent's E lify only highest gr			16a. De	cedent's Usual ve kind of work	Occupa done di retired)	tion uring most of wo	orking	16b. F	and of Bu	siness/li	ndustry	
212	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, Ita M.	Comp	Elementary/Seco	ndary (0-12)	College (1-4or 5+)		ano tea	che	r		_	duca		1	
pu	be filed tal Hygi d other	Be (17. Father's Name								me (First, Midd			-		
Maryland	should band Ments marked umatic e	2	Carter Gi	bson Osb	urn					Marga	ret Nort	ton S	Smith			
ary	sho and h sms		19a. Informant's Na	ame/Relationship (Туре, Print)		19b. M	iling Address (Street a	nd Number or F	lural Route Num	ber, City	or Town, S	State, Zi	p Code)	
	nd 2 alth a 27 is		Johns Jan	ney Hoff	man Jr.	/son	314	Taplov	v Rd	. Bal	timore,	MD	2121	2		
Baltimore,	permit. Pages 1 and 2. Department of Health a Importent: if Item 27 is any injury or other treu 2008.			Cremation 3		State	cemetery, o	position (Name rematory or oth	er place	1	Date		ocation - (•		
altin	rmit. Pa partmer portent y injury ce.		4 LJDonation 21. Signature of Fu	5 Other (Special Service Lice		Gr	eenmo	int cre	Addres	ory Nove	1,2004 efeld Fu Balt:	Bal	timor	re,	Mary.	Land
8	89 5 8 8		John	O. Mate	hell	nauged the dec	th Do not	650	00 Y	ork Rd.	Balt	imore	, MD	21	L212 Approx	
	Physician /Medical Examiner		23a. Part 1. Enter the Strock, or heal Immediate Cause disease or condition resulting in death)	(Final	a. coro		rtery	disease		g, such as cardia	c or respiratory	arrest,			Interva	il Between and Death
68760,	eath certificate be executed attending physician and for use as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.														
P.O. Box 6	be bed	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 9 □ Unknown	months?	1 Live	itcome of pregi birth 2 DFe nant at time of nown	tal death	3 □Ectopic pre 5 □ Other (spe				-	23d. Date Mon		very Day	Year
Ś	w requires that the second of	by	Part II. Other signif	ficant conditions	contributing to c	leath but not re	sulting in th	e underlying ca	use give	n in Part I.						of death?
Record	10 00	Completed							-		24a. Wa		24b. W			4 XX Unknown ings available of cause of
	Th ate pag	Cor									1 ☐ Yes			Yes	2 X No	
/ita	ician: Th certificate ector, pag	Be	25. Was case refer examiner?	rred to medical							ath (Check only	/ опе)				
of Vital	Physician: this certific ral director,	으	1 ☐ Yes 2 🔀			·	ER/Outpa	tient 3 DOA	Othe	4 X Nursing	Home 5 ☐ Re	sidence	6 Othe	r (Spec	ify)	
Division o	te Te	Certification:							ic. Injury Work 1 🔲 Y	at ? ∕es 2∐No	28d. Describe					
Divi	To the Hospitel or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	Certifi	3 🗍 Suicide 4 🗍 Homicide	determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Ro City or Town, State)						al Houte	rvumber,				
	he Hospi n 24 hou he Funer	edicai	29a. Certifier (Check only one)	1X Certifying P 2☐ Medical Exa	minar: On the t											120(2)
	To the comp	ž	29b. Signature and	title of certifier	\ \ \ \ \ \ \	ی اد		29c.	License	number		29d. Da	ate signed	(Month	Day, Ye	

State Registrar

31. Date filed (Month, Day, Year) NOV 1 -2004

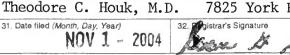
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Decedent's Name (First, Middle, Last)

Margaret Osburn Hoffman

Physician

/Medical



7825 York Rd. Towson, MD

D41104

21204

November 1, 2004

		•	- State Amend Item	State of Ma 1 5 per att	.,G86	2,12/	08/06 thb	Death			04	34511
	Dhusiair	200	1. Decedent's Name (First, Middle, La						2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Joseph B. Han						October	2	2004	101
	Examin		4a. Fecility Name (If not institution, gir	ve street and number)			4b. City, Town,	or Location of Deat	h	4c. Co	ounty of Death	
	Funeral Director		Stella Maris Hosp 5. 2016-28-0360 216-28-3060			st birthday) Yrs.	Balt If Under 1 Year Months Days			ay, Year)		place (State or Foreign intry) yland
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary	tor	Maryland		Ba1	timore	e					1 ☑Yes 2 ☐ No
	h the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Cou	intry?
	th wit		756 Charing Cro	ss Road			212			USA		
bs ep1	permit, Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If item 27 te marked other then "neturel", or items 23e or 28e-f show any injury or other traumatic event, It is Meulcal Evaluinar must be inclined at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 XYes 2 1 1 Yes, Give Year or Dates:			Was Decedent of If Yes, specify Cut 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Span, Mexican, Puer Specify:	pecify Yes or N to Rican, etc.)		Race - Amer Black, White Decify: Whi	, etc.
Q 6	72 hc	Completed	15. Decedent's E (Specify only highest g	Education rade completed)		(Give	dent's Usual Occu kind of work done	during most of wo	rking	16b. Kind	of Business/I	ndustry
HANS, Maryland 2121	vithin ne. hen "	mpl	Elementary/Secondary (0-12)	Coflege (1-4or 5			DO NOT use retire			LIC	atorn	Electric
2 7	Hygie Hygie ther t		17. Father's Name (First, Middle, Las	st)		Produc	CLION CO.	18. Mother's Na	me (First, Middl			Electic
	d ba i	To Be	Joseph Hans	•				Joseph	ine Ste	raowie	ck	
本区	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address (Stree	t and Number or R	ural Route Num	ber, City or T	own, State, Z	ip Code)
	alth a		Ruth Hans	Wife		756	Charing	Cross Ro	ad; Bal	timore	, MD 2	1229
Baltimore.	ages 1 a int of He t: If item y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		ce	metery, crei	osition (Name of matory or other pl. Cremato:		Date 9/04		tion - City or 1 Church	own, State , Virginia
3altir	permit, P Departme Importen any Injur		21. Signature of Funeral Service Lice			22	Name and Addr Sterlin	ress of Facility g Ashton ondson Av	T			
_	40580		23a, Part1. Enter the disease, or co	molications that caused	the death	Do not ent					'ille,	Approximate
	Physician		shock, or heart failure. List onlinediate Cause (Final disease or condition	y one cause on each fi	ne.	りへい	11~	EUN	·			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):						
7		e.	Sequentially list conditions, cause. Enter Underlying	b Due to (or as	a consequ	ence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
68760.	ficate be exacuted physician and ts the burial-transit	I Exa	resulting in death) Last	Due to (or as	a consequ	ence of):						
87	ficate to physical the tast the tast the tast the tast the tast the tast tast tast tast tast tast tast tas	edical		d								
Box	auth certi attending for use a	by Physician/Me	IF FEMALE: 23b. Was decadent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3[□Ectopic pregnan □ Other (specify)	су		230	d. Date of deli Month	very Day Year
0	res that the signed by		Part II. Other significant conditions	contributing to death t	out not resu	ilting in the u	inderlying cause g	jiven in Part I.		tobacco use		the cause of death?
	v requ been should	etec							24a. Wa	san	24b. Were au	toosy findings available
Rec	The lav	Completed							aut	formed?	death?	topsy findings available completion of cause of
-	ctor,	Be C	25. Was case referred to medical examiner?						ath (Check only	one)		
7	hyeid this call dire	ပ္	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpati		ER/Outpatie	III 3 DOA		Home 5 Re		Other (Spec	cify) ~ 0 > ruy
2	ling P	ion:	27. Manner of Death Natural 5 Pending	28a. Date of fnji (Month, Da	ay Year)	28b. Time o Injury	W	uryat ork? ⊒Yes 2. □No	28d. Describe	e now injury (occurred	
Division of Vital Records	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Diractor: After this certificate has completely filled in by the funeral director, page 2 to	Certification;	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e, Place of In	jury - At ho tc. (Specify	me, farm, st	reet, factory, office			(Street and i	Number or Ru	ral Route Number,
C	ospital obours all unerel Dily filled in		29a. Certifier Certifying	Physician: To the best	of my know	wledge, deal	th occurred at the	time, date and place	e, and due to the	e cause(s) a	nd manner as	stated.
	the H iin 24 the F iplete	Aedical	one)	and manner s	tated.					and Date	sizeed (Month	Day Vara
	To To	Σ	29b. Signature and title of certifier	~ {~			29c. Lice	D 40 8	554	1012	200	1. Day, 10ar)
	10/		30. Name and address of person when the same addre	to completed cause of		23a) (Type	, Print)	Pul	PI	Baltin	17/2000	2_
1		ate	31. Date filed (Month, Day, Year)	0-0-01	rar's Signal		Soass	,				
	Regist OHMH 17 Rev 1/2	, N, S	140 A T - 500	The state of the s		-	mous					

ORIGINAL

Jane Handlir 04-06902 RPD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	/ Department o	f Health and	Mental Hygien	PN	nı.	21
	Cartificate	of Donth			0 4	Ú "

			For State Registra MFN TTFM 1. Decedent's Name (First, Middle, Lateral Control of the Control o	28f PER M	E G837 195	oantment of F	Death		g. No.	345 2
П	Physici		JANE ELIZABE		ANDLIR			October	Day 2004	0218 A M
}	/Medic Examin		4a. Fecility Name (If not institution, give	e street and number)			r Location of Death	ו	4c. County of Dea	
			University Hospit			Baltimo:		1000	N/A	
	Funeral Director		5. Social Security Number 215-58-2140 Usual Residence of Decedent	ex 7. Ag □ M 2☐F	e (In yrs. last birthda) 55 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug 13,		rthplace (State or Foreign country) aryland
	yland		10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	e Mar Ba-f si	ctor	Maryland Baltimor	e County	I	owson_				1 ☐ Yes 2 ☐ No
	3a or 2	i Dire	10e. Street and Number 19 Treeway Court	. 1-D		10f. Zip Code	1286	10	og. Citizen of What C USA	ountry?
Maryland 21215-0036	hin 72 hours after death with the Maryland e. an "natural", or Items 23a or 28a-f show Medical Examinar must be Indiffed at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:		B. Was Decedent of Hilf Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
5-0	72 ho 'natur	eted	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Dec (Giv	edent's Usual Occup re kind of work done DO NOT use retired	ation during most of wor	rking	16b. Kind of Busines	,
121	within ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	. <i>DO NOT</i> use retired .e Represe			Retai Departmen	
d 2	led ther	Be Co	12th 17. Father's Name (First, Middle, Last,)	00.2	.с пергозо		ne (First, Middle, A		L SLOIC
/lar		To B	James Carl H	Male			Doris	Elizabet	h Behr	
Jan	d 2 should th and Mer 7 Is marke treumatic		19a. Informant's Name/Relationship (-			City or Town, State,	-1011
	1 an Heal em 2 ther		James Carl Hale (20a. Method of Disposition	Father)		JOGIANS CO position (Name of rematory or other place			, Berlin, 20c. Location - City o	
altimore,	Page ant: If ury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Fundal Service)	(y)	Green Mo	ount Cemet	ery 10/		Baltimore,	
Ba	permit. Departr Imports any inj		Martin D. Lav	awstr	I N	Mitchell-W 500 York	iedefeld Road Ba	Funeral	Home, Inc	21212
	Physician /Medical Examiner	ler	Immediate Cause (Final disease or condition resulting in death)	a	d the death. Do not eine. Maltiple a consequence of):		ng, such as cardiad	c or respiratory arre	sst,	Approximate Interval Between Onset and Death
68760,	tificate be executed ig physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of):					
O. Box	The law requires that the death cert te has been signed by the attending age 2 should be detached for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ★Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	3 □Ectopic pregnanc 5 □ Other (specify) □	у		23d. Date of di Month	elivery Day Year
Q	quires that in signed b uld be deta	by	Part II. Other significant conditions	contributing to death b	out not resulting in the	underlying cause giv	ven in Part I.	23e. Did tob		to the cause of death? Probably 4 □Unknown
Records,		Completed						24a. Was ar autops perform 1 X Yes 2	y prior to	autopsy findings available completion of cause of s 2 No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?	Hoonitely		0#		ath (Check only on	e)	
of	Phys r this ral dii	on: To	1X Yes 2 □ No 27 Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju	ury 28b. Time	of 28c. Inju	ry at rk?	,	ence 6 Other (Sp ow injury occurred	1 1 1
Division	Atten	Certification;	2 Accident investigation 3 Suicide 6 Could not to 4 Homicide determined	28e. Place of th	ijury - At home, farm, tc. (Specify)	street, factory, office	Yes 2 No	281. Location (St. City or Town	STUCK IN reet and Number or F s, State) Property State City,	NOTO: VEMELE BIVD: TOWSON,
	To the Hospitel or within 24 hours after To the Funeral Direction completely filled in	edicai		hysician: To the best miner: On the basis of and manner st	of examination and/or					
	To the within Fo the comple	Med	29b. Signature and title of certifier	2	·····	29c. Licens	se number	29	9d. Date signed (Mor	ith, Day, Year)
	- >- 0		Jameta South	all, mo		0.C.	M.E.	0	ctober 25	2004
6	6		30. Name and address of person who Ramek E. South	completed cause of a	death (Item 23a) (Typ		Street, 1	Baltimore	, Marylan	d 21201
1	Sta Regist	ate rar	31. Date filed (Month, Day, Year) NOV 1 - 20		rar's Signature					

DHMH 17 Rev 12001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** DCTOBER 2004 8:03P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Medical Center Towson Saint Joseph If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 10 M 2□ F Pennsylvana Yrs. 202-07-860 Director Usual Residence of Decede Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked othar than "natural", or Items 23s or 28s-f show ury or other traumatic avant, the Medical Examinating the notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2 No BALTIMORE BALTIMORE Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2123 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 2 🗆 No 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heckler HIP 2 HMMON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type, Print) SON altimore MD 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) 3 Removal from State Department of Important: If any injury or once. 2.04 Morela Tark 21. Signature of Funeral Service L 22. Name and Address of Facility BALTIMORE, MO21234. icensee 8800 HARFORDED EVANS FUNGRALCHAPER WHORK 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician INTRATHORACIC BLEEDING TOPERATIVE /Medical Due to (or as a consequence of). **Examiner** CORONARY ARTERY BYPASS GRAFTING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-transit AND AORTIC VALVE REPLACEMENT attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical CORONARY ARTERY DISEASE use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 □Unknown 1 🗌 Yes ACUTE RENAL FAILURE Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 27. Manner of Death

Natural
2 ☐ Accident 28b. Time of after death. I Diractor: After t Certification: Injury 5 Pending 1 Tyes 2 No investigation Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funeral L Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10-29-04 D30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 FRANCIS KHOO
31. Date filed (Month, Day, Year)
NOV 1 - 2004 7601 OSLER DRIVE TOWSON, MARYLAND 21204 lyl. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiere 0 0 4 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2004 October A^{M} Η. Hopkins, Sr. 28, 3:40 Robert /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Potomac Manor Care-Potomac If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days 11K1 M 2 □ F Yrs. 89 October 12, 1915 Virginia Director 223-10-5588 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Madical Examinar must be notified at 1X Yes 2 □ No Director N/A Salem Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24153 United States 316 Valleydale Avenue Funerai permit. Pages 1 and 2 should be filled within 72 hours after deal Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural!" ~ the any liqury or other traumatic avera. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ₩ Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Insurance 5 Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Elizabeth Hall William Anderson Hopkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12501 Split Creek Court, Gaithersburg, MD 20878 Robert Hopkins/ Son 20b. Place of Disposition (Name of cometery, crematory or other place)
Sherwood
Memorial Park 20c. Location - City or Town, State 20a. Method of Disposition November 1 Burial 2 □ Cremation 3 □ Removal from State 5, 2004 4 ☐ Donation 5 ☐ Other (Specify) Salem, Virginia 22 Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee M01405 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE END DEMENTIA Priysician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed 1 Yes 2 No 2/2/No To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation i Director: A d in by the fi 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a 29a. Certifier 🛮 🚅 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10128104 to can 00057124 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Terrace, Germantown, Maryland 20874 Truong Bao, M.D. 82. Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 - 2004

Amend item #24a, per Verbal, G837, 11-1-04 Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien (2014) 34515 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year _Physician October 28 5:50A 2004 Ε. Ingham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles ear If Under 24 Hrs. 41MOLE etown 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Days Min. Hours 1 ☐ M 2 🔀 F 83 Yrs Sept 17, 1921 Maryland Director 216-12-0791 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or Itama 23a or 28a-f show traumatic event, the Mudical Examinar must be notified at 1 ☐ Yes 2 No Maryland Baltimore Catonsville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 719 Maiden Choice Lane BR232 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? t ☐ Yes 2 ☒ No If Yes, Give Black White etc 2 should be filed within 72 hours after and Mental Hygiene. 1 Mever Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 executive secretary insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nellie Bellokson William Chesney Ingham 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 si of Health ar 18783 Ridge Meadow Road, Stewartstown, Pennsylvania Diane Cunningham - niece 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If the
any injury or ott November 1, 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery Baltimore, Maryland 4 Donation 5 Dother (Specify) 2004 21. Signature of Funeral Service Insurance 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cancer 1 month **Physician** ancrea disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as the cause of th Due to (or as a consequence of) Examiner as the burial-transit certificate be executed and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy at the death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) by the a 1 Yes 2 CHO Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 3 DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After t 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and Me of certific addres of person who completed cose of death (Item 23a) (Type, Print) Choice Lane, Baltimore, MD21228 Phill 711 / laiden 2. Registrar's Signature Year) State NOV Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 001 34516 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17 **Physician** ANTHONY 0. **JOHNSON** OCTOBER 2004 12:17 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1956 9. Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F Months Days Hours 48 215-53-5043 Director August 24 Lagos, Nigeria Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Modical Exercities of 10d. Inside City Limits Director 1 X Yes 2 No MD PRINCE GEORGE'S LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13105 LARCHDALE ROAD # 9 20708 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other treumatic event, the Muclical Examinations. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2K No Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4+ Engineer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Oyesomi Johnson Janet Enumba 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christine Johnson/Wife 13105 LARCHDALE RD. # 9 LAUREL, MARYLAND 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-29-04 Silver Spring, Maryland Gate of Heaven ^¹ 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit attending physicien and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death detached for 5 Other (specify) 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyophathy 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No Renal Fairlure 24a. Was an has autopsy 1 ☐ Yes 2**X** No al or Attending Physician: T s after death. It Director: After this certificat 25. Was case referred to medical examiner? funeral director Be 26. Place of Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2🏝 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 5 Pending Injury 1 XNatural 1 TYes 2 □ No investigation 2 Accident the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funeral I 29a. Certifier Medical 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filod (Month, Day, Year)
NOV 1 - 2004

32. Degistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Sudhakar M.D. 7610 Carol Avenue # 2

230 Takoma Park, Maryland 20912

10-25-04

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

^{Year)}2004

HOSPITAL

32. Registrar's Signature

GOOD SAMARITAN

RES 000

5601 LOCH RAVEN BLVD.

CHAMION OLIVIER

OCTOBER

BALTIMORE MD

25 2004

State Registrar

31. Date filed (Month, Day, Year)

NOV 0 1 2004

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Zahrillah

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Pagistrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, Maryland 21201

October 28, 2004

		Amend item # 20a	Type or Print in 1 -c. per FH 683. State of Marylar	7,11/1/04 T 1 ,11/1/04 T 1d / Departmei	e ink. Ensure A T it of Health and M	II Copies Are Ilental Hygier	e Legible. PANI.	34519
		1 - For State Registrar		Certifica	te of Death	Reg. N		
Physi /Med Exam	dical	Decedent's Name (First, Middle, La. C 4a. Fecility Name (If not institution, giv.)	Jackso	4b. City	, Town, or Location of Death	October	Day Year 28,2004 4c. County of Delath	3. Time of Death 5:30 AM
Funera	Ţ.	6755 Town 5. Social Security Number 6. S			Back Mor or 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthpl	ace (State or Foreign
Directo		Usuel Residence of Decedent	□M 2× 39	Yrs. Months	Days Hours Min.	Nov. 4, 19	64 Mar	ylana
ne Marylar Ba-f show	Director	Mary and 10b. County	A 100. CI		ore			od. Inside City Limits 1 Sys 2 □ No
ath with the 23s or 2	ral Dire	6755 Town	brooke 12. Was Decedent Ever in U	Dr.	2/207		Citizen of What Count	
Ittimore, Maryland 21215-0036 iii. Pages 1 and 2 should be filled within 72 hours after death with the Maryland artirnent of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural" or items 23s or 28s-f show injury or other traumatic svent, the Medical Exercities mark the routilised.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Amed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	13. Was bed If Yes, sp	edent of Hispanic Origin? (Si ecity Cuban, Mexican, Puerto 2 No Specity:	Pican, etc.)	Black, White, e	
21215-0036 Id within 72 hours aff giene. or then "natural", or ithen Medical Exercise.	mpleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wor		Kind of Business/Ind	ustry
faryland 2121 2 should be filed within and Mental Hygiene. Is marked other than raumatic svent, the Ma	To Be Co	17. Father's Name (First, Middle, Last	hasan S	SC.	18. Mother's Nam	ne (First, Middle, Maid	en Sumame)	UD, Care
re, Maryland 1 and 2 should be fill Health and Mental Hy tem 27 is marked oth	F	19a Informant's Name/Relationship (Typo, Print) (mother)	19b. Mailing Address	ss (Street and Number or Ru	ral Route Number, City	y or Town, State, Zip	Code) , 21216
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr		20a. Method of Disposition Burial 2 Commation 3 Commandation 4 Donation 5 Other (Special	Removal from State Mt.		other place)		Lansdowne	
Baltimo	SUCE	21. Signature of Funeral Service Lice	L. Russ	2. Name a Je Se p Z Z Z 2	and Addres Wacility		Home to Md.	21216
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68760 tificate be e ig physician as the buria	70		d					
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of Vital F Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor	th (Check only one)		
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined		home, farm, street, factorify)	ry, office	28f. Location (Street City or Town, Str	and Number or Rura ate)	Route Number,
Hospital or 24 hours afte Funerel Dir letely filled in	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Madicel Exa	nysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, death occurre nation and/or investigation	d at the time, date and place n, in my opinion, death occu	, and due to the cause rred at the time, date a	o(s) and manner as stand place, and due to	ated, the cause(s)
To the within 2 To the comple	Me	29b. Signature and title of certifier	dun	2	9c. License number		Date signed (Month, 1	Day, Year)
3		30. Name and address of person who	completed cause of death (Ite	om 23a) (Type, Print)	so aleans s		nore M)
	State strar	31. Date filed (Month, Day, Year)	32. Registrar's Sign	Spark Spark	la l			

			For State of Registrar	Maryland / Department of Health and Mo	211111 31 530
			Registrar 1. Decedent's Name (First, Middle, Last)		Date of Death 3. Time of Death
	Physicia /Medic		DAVID Gilber	+ Johnson	Month Day Year 3:05P.M
	Examin		4a. Facility Name (If not institution, give street and num	(ber) 4b. City, Town, or Location of Death	4c. County of Death
	F		5. Social Security Number 6. Sex		BALTIMORE 8. Date of Birth 9. Birthplace (State or Foreign
	Funeral Director		218-32-9481. 1XM 20F	106 Yrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) MARYLAN MARYL
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits
	Maryk -f eho fied a	tor	MA PAITIME	PARKVILLE	1 ☐ Yes 2 No
	th the or 28a e noti	lirec	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a	rai	8507 Wendell A.	ie. 21234	USA
"	fter de	Funeral Director	11. Marital Status 1 Never Married 21 Maried 1 Never Married 21 Maried 1 Dress Giv	dent Ever in U.S. ces? 13. Was Decedent of Hispanic Origin? (Sperces? 14. Was Decedent of Hispanic Origin? (Sperces?) 15. Was Decedent of Hispanic Origin? (Sperces?)	cify Yes or No- Rican, etc.) 14. Race - American Indian, Black, White, etc.
5-0036	72 hours after death with the Maryland neturel; or Items 23a or 28a-f ehow Iteel Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced Year or Da	e 1 □ Yes 2 1 No Specify:	specify: White.
15-(n 72 h "netu	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired)	16b. Kind of Business/Industry
2121	d within giene. er than "	Comp	Elementary/Secondary (0-12) College (1	Service Technicia	n BGE
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene is feen 23 or 28a-f ehow teen 21 is marked other than "neturel", or flems 23a or 28a-f ehow other treumatic event, I'm Medical Erani mer must be notified at	Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
Maryland	hould d Men marke matic	၉	19a. Informant's Name/Relationship (Type, Print)	NSON JULIA	Route Number, City of Town, State, Zip Code) 21.231
	nd 2 sho alth and 27 Is m		Jours A. Johnson	-wife. 8507 Wendell Au	PARKUILLE MO
ore,	iges 1 and it of Health if item 27 or other tr		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5	cometany cromatany or other place)	ate 20c. Location - City or Town, State
Baltimore,	permit. Pages Department of Importent: If is any injury or ance.		* 4 ☐ Donation 5 ☐ Other (Specify)	Gardens of Faith Concoking	11-104 Kosedale mis
Ba	permii Depar Impoi any ir once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility	MORE, MD 21234.
			23a. Part1. Enter the disease, or complications that complete the comp	aused the death. Do not enter the mode of dying, such as cardiac or ach line.	respiratory arrest, Approximate Interval Between
A.	nysician		Immediate Cause (Final disease or condition	reventic concer	Onset and Death MbA
	/Medical Examiner		resulting in death)	or as a consequence of):	
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Vi	and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.		
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	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Af completely filled in by the fu	edicai C	29a. Certifier (Check only one) 1 Sertifying Physician: To the base and many one)	best of my knowledge, death occurred at the time, date and place, and sists of examination and/or investigation, in my opinion, death occurre ter stated.	nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(s)
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			· An con	ms 0 58303	octuser 29 2004
	12+1		30. Name and address of person who completed caus	OOOI N. Ona	
	Sta		ALCO A	Towson, MD Sparker	Z1ZU 4
	Registr	ar	/	1 popular	

JOHNSON, DAVID

			1 - For State Registrar	State of Ma	aryland / De	epartmer Certifica	nt of H	lealth a Death	and M	ental Hy	giene Reg. No	200	4	34	521
	Physici	an	1. Decedent's Name (First, Middle, La							2. Date of De. Month	Da	Yes	ır	3. Time o	
ζ	/Medic	al	4a. Facility Name (If not institution, give		ones	4b Cibe	Town	r Location o		Octopo		AA、Ac County of D	400	6:14	1 PM
	Examin	er		karyland t	125034	2		€			10.	. County of D	alli		
	Funeral		5. Social Security Number 6. S		e (In yrs. last birtho	iay) If Under	r 1 Year Days	If Under Hours		8. Date of Birt (Month, Da	h V Vearl	9. 1	Birthpla Countr	ce (State	or Foreign
	Director		219-50-5079	1 Ø M 2 □ F	53 Yr	S. Months	Days	Hours	MID.	February	22,	1951 Ma	ryla	ind	
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location							10	d. Inside (City Limits
	Maryl -f shc lied a	ţō	MD NA		Balt:	imore								1 🔀 Yes	2 □ No
:	or 28a	Funeral Director	10e. Street and Number			10f. Zi	p Code				10g. Cit	tizen of What	Countr	y ?	
-	23a c	a D	2545 W. Fayette Str	eet ·		2	1223					USA			
	tams	nue	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Dece If Yes, spe	dent of H	lispanic Ori an, Mexican	igin? (Spe n, Puerto F	cify Yes or No Rican, etc.)	-	14. Race - A Black, W			
36	rs affe	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 N If Yes, Give Year or Dates:	10	1 🗆 Yes	2 X) No	Specify:				Specify: B1	ack		
21215-0036	/2 hours after death with the Maryland neturel', or Itams 23a or 28a-f show dical Examiner must be notified at	ted 1	15. Decedent's E	ducation	16a. D	ecedent's Usu	al Occup	ation			16b. K	ind of Busine		stry	
215	e. Ren "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5	- //	give kind of w fe. DO NOT t	ork done i ise retired	during mosi i)	t of workin	ng					
	filed within Hygiene. Ither than "	S	11			Labor	er	40.14.1		100		Constr	ucti	on_	
Ξ.	antal H	To Be	17. Father's Name (First, Middle, Last Alpheus Jones	,						(First, Middle, Fitzge		Sumame)			
7	should nd Men marke umatic	۲	19a. Informant's Name/Relationship	Type, Print)	19b. N	lailing Addres	s (Street			Route Number		or Town, State	a, Zip C	Code)	
	and 2		Carolyn Jones/ Sist	er						MD 2122					
ore,	of Head		20a. Method of Disposition 1 □ Burial 2 X Cremation 3 □	Romoval from State	20b. Place of D	isposition (Na crematory or	me of other plac	ce)	Da	ate	20c. Lo	ocation - City	or Tow	n, State	
Ĕ.	Pages ment of t ent: If Ite		`4 ☐Donation 5 ☐ Other (Speci	fy)	Metro Cr	ematory		10)-29- 0	4	Cator	nsville,	MD		
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Insportent: If Item 27 is marked other than "neturel", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.		21. Signature Theral Stylice Lice	nsee Mal	1	22. Name a			-	N. Gilmo	r St.	. Balto,	MD	21217	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not	enter the mo	de of dyin	g, such as	cardiac or	respiratory ar	rest,		3	Approxima nterval Be	tween
F	nysician		Immediate Cause (Final disease or condition	. Preur	nanio									Onset and	VS
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)	1		2						`	-
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oʻ	e exec ien an ırial-tr	Exa	resulting in death) Last	Due to (or as	a consequence of)				-						
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٣.	The law requires that ate has been signed b page 2 should be deta	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in th	e u n derlying	cause giv	en in Part I.	•	23e. Did to	bacco L	use contribute	to the	cause of	death?
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of	ar this aral di	To To	27. Manner of Death	28a. Date of Injur	y 28b. Tim	e of	28c. Injun	y at		ne 5 Resid			oecify)	_	
ion	ath. r: After e funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da) n	<i>i Year)</i> Inju	ry M	Worl	k? Yes 2∐l	No						
Division	r Atte er de: irecto	Certification:	3 Suicide 6 Could not to determined		ury - At home, farm	, street, factor	y, office		2	8f. Location (S City or Ton			Rural I	Route Nun	n <i>ber</i> ,
	urs af								- 1						
:	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination and/o	eath occurred ir investigation	at the tin	ne, date an pinion, deal	d place, at th occurre	nd due to the o d at the time, o	ause(s) date and	and manner place, and d	as stat ue to ti	ed. ne cause(:	s)
, ,	To t Com	Σ	29b. Signature and title of certifier	,		29	c. Licens	e number				te signed (Mo			
	1		John ,	~~,	WD b		1140	6435	DIST	58	٥٥	tober	20	1,20	400
	(30. Name and address of person who	completed cause of de			<i></i>		-11.						
	Sta	te	31. Date filed (Month, Day, Year)		ar's Signature	-00		, 6	91411	more	,_ (Y)	ש א	120	21	
	Registr		NOV 1 - 2004	Serve	~ 13	Spon	Kal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 10 1 34522 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** LIPFORD 2152 JOAN OCTOBER 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** THE JOHNS HOPKINS HOSPITAL BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/11/1934 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 7 F 70 Director 217-30-5074 MΑ Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "neturel", or Items 23s or 28s-f show the Medical Examiner must be notified at 10d. tnside City Limits 1 ☐ Yes 2 No Baltimore MD Anne Arundel Direct 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code 21225 Funeral U.S.A. 114 Wallace Avenue Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2. No Specify: Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygiens Importent: If item 27 ie marked other tha any injury or other treumatic event, Ins. 2008. <u>Homemaker</u> Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Donald C. Lee Chloe Van Ostrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Lipford/Son 1009 Longstream Court, Bel Air, MD 21014 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Meadowridge Mm Pk 11/02/04 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility G.J.Gonce Funeral Home, PA Zu 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCREATIC ADENOCARCINOMA 9 MONTHS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-trans attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetat death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospitat: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☑ No 27. Manner of Death 28c. tnjury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: after death. Director: After 1 Natural 5 Pending Injury 1 Tes 2 No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Wilnums Malek, MEDICAL DOCTOR RES-000 OCTOBER 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLFE STREET, BALTIMORE, MD 21287 AdnAN MALIK 0

Registrar DHMH 17 Rev 1/2001

State

600 NORTH

NOV 0 1 2004

31. Date filed (Month, Day, Year)

32. Registar's Signature

		•	For State Registrar	State of Marylar		artment of H		Mental Hygien	211111.	34523
	•		1. Decedent's Name (First, Middle, L	*				2. Date of Death	ay Year	3. Time of Death
	Physicia /Medic		WAYNE D	nrrel LAF	Fooi	2		OCTOBER	29,2004	8:40 FM
>	Examin		4a. Facility Name (If not institution, g Saint Joseph		nter	4b. City, Town, or	Location of Death		ec. County of Death Balt	imore
	Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs. 125M 2□ F	. last birthday)	tf Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	r) Coun	lace (State or Foreign try) CAID; IL
	puq		Usual Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	ncation			10	Od. Inside City Limits
	Aaryla f shore	ō			EKUN				."	1 ☐ Yes 2 No
	28a-i	rect	10e. Street and Number	HALCHET LE	COIL	10f. Zip Code		10g. C	Citizen of What Coun	
	death with the Maryland rms 23a or 28a-f show rmust be notified at	i D	34 TOMMY	TRUE COUL	21	2123	541		1).S.A.	
	deatl	Funerai Directo	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		Was Decedent of H	ispanic Origin? (Sp	pecify Yes or No-	14. Race - America	
920	should be filed within 72 hours after death with the Marylan of Mental Hygiens are marked other than "natural", or leams 23a or 28a-f show marked other than "natural", or leams 23a or 28a-f show marked other than "natural", or leams are must be notified at	þ	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced		-	1 ☐ Yes 2 No	Specify:	rican, etc.	Black, White, o	HITE
2-003	72 hor		15. Decedent's (Specify only highest of			dent's Usual Occupa		16b.	Kind of Business/Ind	iustry
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Maryland 2121	d be find the orthographic states of the orthogr	Be o	17. Father's Name (First, Middle, La.	SEL LAFFOO				e (First, Middle, Maide	on Sumame)	DEI/
2	d 2 should th and Men 7 Is marke traumatic	은	19a. Informant's Name/Relationship			ng Address (Street a	and Number or Rur	ral Route Number, City	or Town, State, Zin	Code)
<u>≅</u>	h a 7 1s		SHARON LAFF	· · · · · · · · · · · · · · · · · · ·	34	TOMM	JTOSAF	COLPY	PACKUULI	E. MD
ē,	1 a He He the		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	0 0	Date 20c.	Location - City or To-	
Ë	0 0		1 ☐ Burial 2 ★ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control C	I Hemoval from State		BEL AIR			EST HILL	C. MD
altimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lie	#nsee	-	2. Name and Addres	-	1005 CHA	AL OF	MEMORIES
m	90 5 5 6	1/1/	MOSTE	NIONZZ	08	4/4 008	RECKD!	RD. BA	TIMBEE.	MD212341
П			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ceused the dea ly one cause on each line.	th. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arrest,		Approximate Interval Between
, 1	Priysician	1	Immediate Cause (Final disease or condition	_a METASTATI	C CAR	CINOMA	OF THE I	LUNG TO		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):					
6		5	Sequentially list conditions,	b. FRONTE		E.				
13	ted nsit	nine	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury							
 -	al-tra	Examiner	that initiated events resulting in death) Last	c. CORONARY Due to (or as a consec		Y DISEA	SE			
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai 1	•	d SEVERE CH	HONIC	OBSTRU	CTIVE P	ULMONARY	DISEASE	
9	artifice ing ph e as t	Med	IF FEMALE:			18311-2-1			-	
Вох	eath certific attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet	al death 3	Ectopic pregnancy		1	23d. Date of deliver Month	ry Day Year
o O	at the dea by the a stached for	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of o	death 5[Other (specify)				24, 154.
<u> </u>	that the ed by detac	/ Ph	Part II. Other significent conditions	contributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did tobacco	use contribute to the	e cause of death?
Records,	quires tha n signed uld be del	ed by	END STAGE RENAI	-				1 XYes	2 □ No 3 □ Proba	ably 4 Unknown
00	aw requir s been si 2 should l	Completed	DIABETES MELLIT	?US				24a. Was an	24b. Were autop	osy findings available inpletion of cause of
_	The lav	шо						autopsy performed? 1 Yes 2 3 1	prior to com death? Io 1 Yes	2 No
Vital	itcian: Th certificate rector, pag	Be C	25. Was case referred to medical	- CONTONIS			26. Place of Deat	h (Check only one)	10 103	7
<u>_</u>	hysician: nis certific I director,	To	examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatier	nt 3□ DOA Othe	er: 4 🗆 Nursing Ho	ome 5 Residence	6 ☐Other (Specify)
0	ng Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Cate of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	/ at </td <td>28d. Describe how inj</td> <td></td> <td></td>	28d. Describe how inj		
Sio	tendi leath. tor: A the fu	cati	Accident investigat 3 Suicide 6 Could not	he			Yes 2 □No			
Division of	or At after of Direct in by	Certification:	4 Homicide determine		nome, farm, sti ify)	reet, factory, office		28f. Location (Street a City or Town, Sta	and Number or Rural te)	Route Number,
	poltal		29a. Certifier Certifying	Physician: To the best of my kn	owiedne deat	h occurred at the tim	e date and place	and due to the cause/	s) and manner as ets	ated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	Medical	(Check only 2 Medical Ex	aminer: On the basis of examination and manner stated.	ation and/or in	vestigation, in my op	oinion, death occur	red at the time, date a	nd place, and due to	the cause(s)
	To the comp	Σ	29b. Signature and title of certifier	-10		29c. License	number	29d. D	ate signed (Month,	lay, Year)
			Celialle	2 214		DØØ	25886	00	1. 30/	2004
	α		30. Name and address of person wh	o completed cause of death (Ite-	m 23a) (Type,	Print)				
	9		31. Date filed (Months Paye, Year)	32. Registrar's Sign	11 OSL	ER PRIVI	E TOWSOI	WARYLE	ND 2120	-
	Sta Registr		31. Date filed (Norths Day, Year)	104	P	poorte				
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	Physici		Jay Lewis	si)				Month Octobe	Day	Yeer 2004	9:00A M
). 	/Medic Examir		4a. Facility Name (If not institution, giv Sinai Hospital o	e street and number) Baltimore			or Location of Dea	th	4c. Co	ounty of Death	1
	Funeral Director		5. Social Security Number 216-84-5333	<u> </u>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ay, Year)	9. Birthp	place (State or Foreign htry) Yland
	Maryland	tor	Usual Residence of Decedent 10a. State Maryland N/A	10c. City B	Town or Lo	ocation Nore				1	0d. Inside City Limits X□ Yes 2□ No
	th with the 23a or 28a in be roll	Funeral Director	10e. Street and Number 2531 Boarman A	venue		10f. Zip Code 21 2	215		10g. Citize	n of What Cour A	ntry?
036	be filed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Eratic for must be recitied at	by	11. Marital Status Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 🖾 No		Specify Yes or No to Rican, etc.)		Race - Americ Black, White, pecify: Bla	etc.
1215-0		Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retire	oation during most of wo d)	nrking		of Business/In	dustry
, Maryland 21215-0036	should be filed nd Mental Hygid marked other umatic event, L	Be	10th grade 17. Father's Name (First, Middle, Last James Lewis		Jan	itor		me (First, Middle Y Powe	, Maiden Su		iiquors
	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship (Shirley Lewis/		19b. Mailir 2531	ng Address (Street Boarman					
Baltimore,	a 0		20a. Method of Disposition X□ Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Special	Removal from State	metery, crer	osition (Name of matory or other pla on Cemet	tery 10	Date -26-04		tion - City or To	
Balt	permit. Pag Department Important: I any injury o		L Joseph	n	52	240 Rei	stersto	wn Rd I	Balti	s Fune	eral Home Md 21215
	Physician /Medical		23a. Pan . Enter the disease, or come serick, or hear failure. List only Immediate Cause (Final disease or condition resulting in death)	a Sepsis		ter the mode of dyir	ng, such as cardia	c or respiratory a	irrest,		Approximate Interval Between Onset and Death 5 days
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,09	cate be executed physician and s the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Disseminated Due to (or as a consequ	ence of):	avascular	Coaqu	lation			2 days
.O. Box 68760,	death certifi e attending ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcome of pregnan 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	□Ectopic pregnanc: □ Other (specify) _	y		230	d. Date of delive	ery Day Year
Δ.	The law requires that the de ite has been signed by the a age 2 should be detached i	by	Part II. Other significant conditions of	contributing to death but not resu	ilting in the u	nderlying cause giv	ren in Part I.	_	tobacco use		ne cause of death? ably 4 Ounknown
al Records,		Completed						24a. Was auto perfo 1 Yes			psy findings available inpletion of cause of 2X No
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Division	tal or Attenders after death al Director:	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (City or To		lumber or Rura	l Route Number,
	To the Hospital or Ati within 24 hours after d To the Funeral Direct completely filled in by	edical	(Check only 2 Medical Example)	nysician: To the best of my knowniner: On the basis of examinat and manner stated.	vledge, death ion and/or in	vestigation, in my o	pinion, death occ	e, and due to the urred at the time,	date and pla	ace, and due to	the cause(s)
	To the within To the Comple	Ψ	29b. Signature and title di certifier	Medical Doctor		29c. Licens				ev 15,2	
	/、\		30. Name and address of person who	completed cause of death (Item	23а) (Туре,	Print)			, 1		

Baltimore

State Registrar KITTANE

31. Date filed (Month, Day, Year)

VISHNIUPRIYA 2401 West Belvedere Avenue

2004

32. Register's Signature

			For State Registrar	State of Ma	aryland	d / Depa	artment of H	lealth a Death	and Me	ental Hyg	ien 2 0	04	34525
	Physicia	an	1. Decedent's Name (First, Middle, Last)			т.	.			 Date of Dea Month 	Day	Year	3. Time of Death
,	/Medic	al	Adele 4a. Facility Name (If not institution, give s	treet and number)		Le	4b. City, Town, o	r Location	of Death	oct	27	200 y	8 4
1	Examin	er	The Hebrew Home of		r Was	hingt			Sprit	ng	М	iontgor	merv
	Funeral		5. Social Security Number 6. Sex	7. Age		ast birthday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birth	Vanel	9. Birtho	lace (State or Foreign
	Director		101-14-0331	M 2XXF	81	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Feb • 6,	1923	Nev	V York
	and w	-	Usual Residence of Decedent 10a, State 10b. County		10c. City.	Town or Lo	ocation					1	0d. Inside City Limits
	e Marylan 3e-f show	Director	Maryland Montgome	ry			Silve	r Spi	ring				1 □ Yes 2X No
	h with th	al Dire	10e. Street and Number 10815 Lombardy Ro	l.			10f. Zip Code	2090)1	1	Og Citizen o	f What Cour .d Stat	-
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Itema 23e or 28e-f show any injury or other traumatic event, I'm Medical Examinant the rights of an once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent I Armed Forces? 1 Yes 2 Y If Yes, Give Year or Dates:		1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Or an, Mexica Specify:		cify Yes or No- lican, etc.)		ace - Americ lack, White, hify: W	
9	2 hou	De l	15. Decedent's Educ	ation		16a. Dece	dent's Usual Occup	ation			16b. Kind of	Business/Inc	dustry
Maryland 21215-0036	within 7: iene. then "n	Completed by	(Specify only highest grade	College (1-4or 5	i+)		kind of work done DO NOT use retired acher	during mos 1)	st of workin	g	Edu	.catio	n
d 2	Hygi other	Be Co	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle,			
ylan	12 should be filed within n and Mental Hygiene. Fis marked other then "Taumatic event, the Me.	To B	Charles	Fred					Paul:				(Unknown)
	nd 2 sh alth and 27 is m r traum		19a. Informant's Name/Relationship (Type Janet Jackel / Da				ng Address <i>(Street</i> toney Bro					n, State, Zip 17733	Code)
Jre,	as 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Pla	ace of Dispo	osition (Name of matory or other place	(e)	Da	ate	20c. Location	n - City or To	wn, State
<u>Ë</u>	Page nent ant: If ury o		1 ☐ Burial 21XCremation 3 ☐ Ri '4 ☐ Donation 5 ☐ Other (Specify)	smoval from State	Che	sapea	ke Cremat	ory	10/28	8/04	Be1t	sville	e, MD
Baltimore,	permit, Pages: Department of H important: if ite any injury or ot once.		21. Significance of Funeral Service Lightness	Holla	M	/ R	2. Name and Addre app Funer 33 Gist A	al ar	id Cre	emation er Spri	Servi	ces 209	910
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused e cause on each lir	the death.								Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)		Tho.		Parci no	m ==	- 1	netas	tutic		Onset and Death
	Examiner			Due to (or as	a consequ	ence of):							
		Je.	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as	a conseque	ence of):							
,	cuted nd ransit	Examiner	that initiated events										
90,	sician and burlal-transit	ai Ex	resulting in death) Last	Due to (or as	a consequ	ence of):							
8760,	cate b	dicai	d			<u>-</u>						-	
Box 6	death certific attending pl	/Me	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome							23d. D	ate of delive	rv
	death ne atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4□Pregnant at 9□Unknown			Ectopic pregnancy Other (specify)						Day Year
P.0	that the de ed by the a detached	Phys	9 Unknown			h''				00- Dida-			
rds,	sign d be	ed by	Part II. Other significant conditions con	tibuting to death bi	ut not resul	ug in the u		en in Parti			es 2 No	3 Prob	ably 4 Unknown
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of	Phys this aldi	<u>۲</u>	1 Yes 2 No	28a. Date of Injur		R/Outpatier 28b. Time o		الا السهقي		e 5 Reside			")
O	Jing After fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	y Year)	Injury	Wor	k? Yes 2□		od. Dosonbo n	W Hijary Occo	21100	
Division	i or Attending i after death, Director: After I in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At hon c. (Specify)	me, farm, str	reet, factory, office		2	8f. Location (St City or Town	reet and Nurr n, State)	nber or Rura	l Route Number,
	spitai nours a nerai C		29a. Certifier 1 Certifying Phys	ician: To the best	of my know	vledge, deat	h occurred at the tir	ne, date ar	nd place, a	nd due to the ca	ause(s) and m	nanner as st	ated.
	To the Hospital or within 24 hours after To the Funeral Dirt completely filled in I	Medical	(Check only 2 Medical Examir	er: On the basis of and manner sta	examination of the second	on and/or in	vestigation, in my o	pînion, dea	ath occurred	d at the time, d	ate and place	, and due to	the cause(s)
	To To Com	2	29b. Signature and title of certifier	. 1			29c. Licens			j	9d. Date sign	ed (Month, I	Day, Year)
	1		Consul 1	house	mp		Die	1490	7		oct	27	2004
	V		30. Name and address of person who co	mpleted cause of d	eath (Item	23a) (Type,	Print) 6121 Rock	m.	whose	c Ri	and s	رم د	
	Sta Registr	4	31. Date filed (Month, Day, Year) NOV 1 - 2004	32/ Registra	ar's Signati	ure [s]	Sporks	/	,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 004 34526 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Edward W. Mogowski October 28, 2004 12:41 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 522 Piccadilly Road Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 18, 5. Social Security Number 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) Birthptace (State or Foreign Country) **Funeral** Year)922 Mary Tand 82 Yrs. 213-18-0336 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23e or 28e-f show 1 ☐ Yes 2 ☐ No Directo MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Piccadilly Road 21204 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give th and Mental Hygiene. 7 Is marked other than "neturel", or Items treumetic event, The Medical Examinal ma Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: white ģ 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Attorney Law 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stefan Mogowski Josephine Dobkevicz ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other tree QDG9. Marsha D. Mogowski / daughter 1647 Hugo Circle; Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify entombment Dulaney Valley Mem Gardens 11/1/04 Timonium, MD 22. Name and Address of Facility RUCK TOWSON Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Fu er Il Service L, ensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIA **Physician** CUTE /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ SQUAMOUS CEU 1 Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No this ā 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Director: After d in by the funera Injury 1 🕒 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours at the Funeral D mpletely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 7 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3482 29 1341 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DRIVE SVITE 101 TOWSON MD

DHMH 17 Rev 1/2001

State Registrar

JAMES

31. Date filed (Month, Day, Year)

NOV 1 - 2004

EBELING

MD

32. Registrar's Signature

7401

			For State of Maryla	and / Department of Health Certificate of Death		2004 34321
	ysicia		1. Decedent's Name (First, Middle, Last)	er	2. Date of Death	Day Year 3. Time of Death 26, 2004 547 p M
	Medic camin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death	4c. County of Death
	neral		5. Social Seducity Number 6. Sex 7. Age (In yr	rs. last birthday) If Under 1 Year If Under 1 Year Hours Yrs. Months Days Hours	r 24 Hrs. 8. Date of Birth Min. (Month, Day, Yea	ar) 9. Birthplace (State or Foreign
Dire			Usual Residence of Decedent	City, Town or Location	January 9,1	964 M/)
ie Maryla 8a-faho	e pailite	ctor	MD N/A	Baltimore		1 ☐Yes 2 ☐ No
th with the 23a or 2	nat be n	Funeral Director	210 S. Bruce St.	10f. Zip Code 2123	10g.	Citizen of What Country?
U KIKISTONOSO filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f ahow	metic event, it a Madical Examiner must be notified at		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Or If Yes, specify Cuban, Mexica		14. Race - American Indian, Black, White, etc. Specify: Black
72 hours	dical Ex	eted by	3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during mos life. DO NOT use retired)	st of working	. Kind of Business/Industry
AIAI ad within giene er than	Ine Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Mover		SelF
IIII	other traumatic event, ILe M	To Be (17. Father's Name (First, Middle, Last) Down O C. Millen	18. Moth	ner's Name <i>(First, Middle, Maid</i>	(en Surname)
s, INIGITY and 2 sho ealth and A	r traume		19a. Informant's Name/Relationship (Type, Print) James Miller/Brother	19b. Mailing Address (Street and Numb 3430 Edmon		
7 - E E	or othe	Ì	1 Burial 2 Cremation 3 Removal from State	Place of Disposition (Name of cemetery, crematory or other place) 4 - Carnel Cen.		Location - City or Town, State althouse, KED
Darinino permit Page: Deparment o	any in ury or once.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Servi * Licensee			Semvre, P.A
			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.	eath. Do not enter the mode of dying, such as	s cardiac or respiratory arrest,	Approximate Interval Between
Priysi /Med	lical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a cons	spiratory failure 2	to Preur	Onset and Death
Exam		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a sins	equence of):	odeficiency	iyndrome
of ou, ate be executed hysician and	the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a cons	equence of):		
no / ou ficate be e	s the bur	licai	d			
The law requires that the death certific ate has been signed by the attending p	should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 2 □ Unknown 23c. If yes, outcome of pregnant at time of the past 12 months? 4 □ Pregnant at time of the pregnant at time	etal death 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
s that the	e detach	by Phy	9 Unknown Part II. Other significant conditions contributing to death but not r	esulting in the underlying cause given in Part	I. 23e. Did tobacc	o use contribute to the cause of death?
w requires to been signer	should b				1 ☐ Yes	2 No 3 Probably 4 Unknown
ar ne n: The lar ficate has	page 2	Completed			autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? yo 1 Yes 2 No
hysician his certif	Il directo	To Be		☐ ER/Outpatient 3☐ DOA Other: 4☐ No	e of Death (Check only one) ursing Home 5 \(\subseteq \text{Residence} \)	6 □Other (Specify)
anding Phath.	ne funera	atlon:	27. Monner of Death 1 Alatural 5 Pending 2 Accident investigation 28a. Dite of Injury (Month, Day Year)	28b. Time of lnjury at Work? M 1 Yes 2	28d. Describe how in	jury occurred
al or Atta	d in by th	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, street, factory, office cify)	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
UNISION OF VICE THE PROPRIET OF THE PURPORT OF	letely fille	edical C	29a. Certifier (Check only one) Certifying Physicien: To the best of my k Medical Examiner: On the basis of examinand manner stated.	nowledge, death occurred at the time, date ar nation and/or investigation, in my opinion, dea	nd place, and due to the cause ath occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the within	comp	Me	29b. Signature and title of certifier	29c. License number	13 29d. E	Date signed (Month, Day, Year)
	8		30. Name and address of person who completed cause of death (K	em 23a) (Type, Print)	Hornita O	700007
	Sta egistr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	nature A Land	14-0 40. (000	

DHMH 17 Rev 1/2001

Miskimon, PATRICIA A

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Maryland / Depa	artment of Health and N rtificate of Death	Jental Hygie		34528
	Physici /Medic		1. Decedent's Name (First, Middle, Last	Ann Miskimon	J.	2. Date of Death Month	Day Year 2004	3. Time of Death //20 P M
	Examir Funeral Director		4a. Facility Name (If not institution, give Citizews No 5. Social Security Number 6. Se	street and number) rsing Home	4b. City, Town, or Location of Death Houne De Gpace If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	ar) Count	
		tor	Usual Residence of Decedent 10a. State 10b. County HARFO	10c. City, Town or Lo	ocation AiR	1-7-47	10 mA	Od. Inside City Limits 1 Yes 2 No
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-1 show other than "natural", or items 23e or 28e-1 show event. I'm Medical Exerting result be notified at	Completed by Funeral Director	10e. Street and Number 421	12. Was Decedent Ever in U.S. Amed Forces? 1	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify: dent's Usual Occupation kind of work done during most of work DO NOT use retired)	pecify Yes or No- Rican, etc.)	Citizen of What Count USA 14. Race - America Black, White, e Specify: USA . Kind of Business/Ind	an Indian, atc.
Maryland 21	d 2 should th and Mer 7 is marke traumatic	To Be Cor	17. Father's Name (First, Middle, Last) Ve RNON 19a. Informant's Name/Relationship (T) Gerald W. Mis	CIN	18. Mother's Nam 18. Mother's Nam GRACI ng Address (Street and Number or Rui Underwood Lan	e (First, Middle, Maid F F 10 al Route Number, Ci	nnery	
Baltimore,	permit. Pages 1 and in Department of Health Important: If item 27 any injury or other truence.		20a. Method of Disposition 1	Removal from State 20b. Place of Dispo cametery, crer	sition (Name of matory or other place)	Date 200 28-04 E SEW PORT	Location - City or Tov Sel Air, 1 DR. FORES AIR MD 21	nD + Hill
8760,	Physician by secuted by sician and by sician and street by sician and street st	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ications that caused the death. Do not entrie bause on each line. a. End Stage Due to (or as a consequence of): Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac	r or respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 6	The law requires that the death certificate be executed tile has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of deliver Month	y Day Year
Ω.	w requires that been signed by should be deta	þ	Part II. Other significant conditions co	ntributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc	2 No 3 Proba	
of Vital Records,	ician: certifica rector, p	Be Completed	25. Was case referred to medical examiner?	Hospital:	0. 1.4	autopsy performed 1 ☐ Yes 2 ☑ h (Check only one)	prior to com death? No 1 ☐ Yes 2	pletion of cause of
Division of	tending leath. tor: After the funer	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, str building, etc. (Specify)	f 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	and Number or Rural	
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical Ce	29a. Certifier (Check only one)	/siclan: To the best of my knowledge, deat iner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, vestigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as sta and place, and due to	ited. the cause(s)
	To the I within 2. To the I complet	Ž	29b. Signature and title of certifier Leeky	, MD	29c. License number D0058904	29d.	Date signed (Month, D	ay, Year)
			Ha J. Lee	ompleted cause of death (Item 23a) (Type,	ALIGINIA LIGIT	re de Gr	ace, MP21	078
	Sta Registi		31. Date filed (Month, Day, Year) NOV 1 - 2	32. Registrar's Signature	Spark			

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 20 34529 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Year **Physician** 30, 12:03a M Robert Fowler Miller II /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 2, 1944 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6. Sex **Funeral** 1**X** M 2□ F Months Days Hours Min. 220-48-0962 60 Director Usual Residence of Decedent with the Manyland 10c, City. Town or Location 10a, State 10b. County 10d. Inside City Limits or Items 23a or 28e-f show the Medical Exer litter; wat be notified at 1 ☐ Yes 2 🕅 No Director Md. Carroll Hampstead 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2362 Fairmount Rd. 21074 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11 Marital Status Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 Is marked other than "naturel", or Ite other traumatic event, I're Madical Ext...II'ru 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2/2/No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Episcopal Church 12 Clergyman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Greer Miller Dorothy Proctor ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2362 Fairmount Rd., Hampstead, Md. 21074 of Health Erika Miller - Wife Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State = 6 Department of Importent: If eny injury or once. Metro Crematory Nov. 1, 2004 Baltimore, Md. ^¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Furneral Service Licensee Eckhardt Funeral Chapel, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cluse on each line. Md. 21102 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No 9 🖂 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 Yes 2 No 3 Probably 4 Ninknown been signated 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has e 2 page 2 No 1 🗆 Yes To the Hospital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 2 1 Inpatient 20 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P00519 October, 30,2000 address of person who completed cause of death (Item 23a) (Type, Print) Jama 247 3 Manche March esq

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month

32. Registrar's Signature

			1 - State Registrar	State of Maryl	and / Depa <i>Ce</i>	artment of H	lealth and M <i>Death</i>		er 2 004	34530
		5	1. Decedent's Name (First, Middle, Last)		-	**		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Asher Mikaelian					October	29, 2004	3:25A M
>	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	EL,		Montgomery Hospi	ce Casey Ho	ıse	Rockvil			Montgome	cy
	Funeral Director		103=07=1149	IN OFF	93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) Apr. 25.	(ear) 9. Birth Cou	place (State or Foreign ntry) York
	and *		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	/anyta	5	Florida Manatee		ongboat					1√TxYes 2 □ No
	the t	Director	10e. Street and Number	1 10	Jiigboat	10f. Zip Code		100	g. Citizen of What Cou	intry?
	3a or	ā	2110 Harbourside	Drive Unit	511	34228		1	nited Stat	
	death ms 2	era		12 Was Decedent Ever i			ispanic Origin? (Spe an, Mexican, Puerto I		14. Race - Amer	ican Indian,
Maryland 21215-0036	d within 72 hours after death with the Maryland jene. ir than "natural", or Itams 23a or 28a-f ehow The Medical Exactions from the redified at	by Funeral I	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	in, Mexican, Puerto i Specify:	Hican, etc.)	Specify: Wh	ite
0	72 ho	Completed	15. Decedent's Edu (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of workii	16	3b. Kind of Business/li	ndustry
21	within 7 iene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	ding most of working	<i>'</i> 9		
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밀	should be filed wind Mental Hygies marked other tumatic event, the	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		,	
<u>X</u>	as 1 and 2 should b of Health and Ment of Itam 27 Is markac r other traumatic e	ဥ	Garabed Mikaelia					Mardiro		
Mar	12 sh h and 7 Is m		19a. Informant's Name/Relationship (Ty						City or Town, State, Zi	
ď.	1 and Health		Gerald A. Mikaeli 20a. Method of Disposition		b. Place of Dispo		ay, Haines		ew Jersey Oc. Location - City or T	08036
Baltimore,	ages or of h		1 Burial 2 □ Cremation 3 □ P		cemetery, crei	natory or other place	(e) Narra	iber 3,	oc. Location - City of 1	OWII, State
Ħ,	it. Pag rtment rtant: njury		'4 □ Donation 5 □ Other (Specify) 21. Si □ Funeral Service Lidense			rsh Memor ark		Art A Dr	mbler, Per	nsylvania neral Home/
Bal	permit. Pages : Department of H Important: If its any injury or ot once.		21. Si Spuneral Service Littles		3000 B	ethesda-C	hevv Chas	e, Inc. 20814-3	7557 Wieco	nsin Avenue
Þ			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	cations that caused the cause on each line.	leath. Do not en	er the mode of dyin	g, such as cardiac o	r respiratory arres	t,	Approximate Interval Between Onset and Death
A	Physician		Immediate Cause (Final disease or condition	Left Hemi	spheric	Cerebrova	ascular Ac	cident		Oriset and Death
	/Medical Examiner		resulting in death)	Due to (or as a con	sequence of):					
	- Adminion	er	Sequentially list conditions,). — Due to (or as a con						
	per tist	nine	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	эвцивнов (н).					
	xecul and	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):					
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687	ficate physics the	edical								
Вох	death certific e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre					23d. Date of deliv	ery
ñ	death e atte d for	lcia	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time]Ectopic pregnancy] Other (s <i>pecify)</i>			Month	Day Year
0	the y th	hys	9 🗆 Unknown	9□ Unknown						
5, Р	The law requires that te has been signed b page 2 should be deta	by P	Part II. Other significant conditions con	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
İ	w require been sig should b							1 ☐ Yes	2 □ No 3 □ Pro	bably 4 X Unknown
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œ .	The rate has page	m o						performe	ed? death?	
ita	ician: T certificat rector, pa	Be C	25. Was case referred to medical examiner?				26. Place of Death			
of <	d is	2	1 ☐ Yes 2 🛣 No	lospital: 1 Inpatient	2 ER/Outpatier	nt 3□ DOA Oth	er: 4 🗆 Nursing Hon	ne 5 🗆 Residen	ce 6 AOther (Speci	fy) Hospice
		on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Yea	28b. Time o Injury	28c. Injun Worl	y at 2 k?	8d. Describe how	injury occurred	
sio	at at	cati	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No			
Division	or Attendate deat Director; in by the	Certification;	4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	tt home, farm, sti <i>ecify)</i>	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Rur State)	a <i>l Ro</i> ute Number,
	urs a	-	20a Cartifica 1 December 2 Physics	niciona To the best of an	lanalandana adana				(-)	tata d
	To the Hospital or Attervalue of the within 24 hours after de To the Funeral Direct completely filled in by the	edica	29a, Certifier 1 Cartifying Physics (Check only one) 2 Madical Examination	sician: To the best of my ner: On the basis of exam and manner stated.	kilowiedge, deat nination and/or in	vestigation, in my o	ie, date and place, a pinion, death occurre	and due to the cau and at the time, date	se(s) and manner as s e and place, and due t	o the cause(s)
	ro th Mithin Fo th	₩ We	29b. Signature and title of ertificial	110		29c. License	e number	290	I. Date signed (Month,	Day, Year)
	1		XXIIII	The			4171	19	10/20/1	74
	15		30. Name and address of person who co	impleted cause of death (item 23a) (Type.	Print)	1+00		7-1/0	
	\		Charles Harriso			,	Road, Roo	ckville,	Maryland	20855
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	4				
	Registi	ar	NOV 1 - 200	4 Depure	19	Sparks	/			

	1 - For State Registrar	State of Man	Cei	rtificate of	Death			34531		
	Decedent's Name (First, Middle, Las.	*)		inoute of	Dealit	2. Date of Death	g. No.	3. Time of Death		
ician	Lucille Mitc					Month	Day Year			
dical	4a. Facility Name (If not institution, give			Ab City Town	or Location of Death		4c. County of Deal	<u>4:10A ™</u>		
niner	Wilson Health Ca	,					3.0			
	5. Social Security Number 6. Se		In yrs. last birthday)	Gaithe		9 Date of Righ	Montgome			
al or	,	M 201 8	•	Months Days		8. Date of Birth (Month, Day, July 21,	1918 Wis	hplace (State or Foreign puntry) CONSIN		
	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits		
rai Director	Maryland Montgome		Gaithe					1⊠Yes 2 No		
Director	10e. Street and Number		- Carene	10f. Zip Code		10	g. Citizen of What Co	L		
0	301 Russell Avenu	۵			20877		Inited Sta			
era	11. Marital Status	12. Was Decedent Eve	er in U.S. 13. V				14. Race - Ame			
Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No	1	f Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	Rican, etc.)	Black, Whit			
b	3 ∰Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1⊡Yes 2∑XNo	Specify:		Specify: Wh	nite		
Completed	15. Decedent's Edi (Specify only highest grad		16a. Deced	tent's Usual Occu	upation a during most of work	ana 1	6b. Kind of Business/	Industry		
ig.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	oo Not use retire	ed)					
S	12		Univers	ity						
Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)									
2	Harry Prasser Edna Greuel									
	19a. Informant's Name/Relationship (T						City or Town, State, 2			
	Paul D. Mitchell, III / Son 365 Cleek Drive, Summerfield, North Carolina 273									
9000 1	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	M(lications that caused the ne cause on each line.	01356 Ro e death. Do not ente	ckville, ckville, er the mode of dy	, Inc. 300 Maryland ing, such as cardiac	West mor 20850-2	ntgomery A 2805	Approximate Interval Between Onset and Death		
al	disease or condition resulting in death) a. Respiratory Failure Due to (or as a consequence of):									
	Consumption line and discon	Aspiration Pneumonia								
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a c								
xam	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c								
-		•	onsaquanca or).							
dic		d								
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ XNO 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)									
ysician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 € 4 Pregnant at tim	Fetal death 3		Sy		23d. Date of deli Month	very Day Year		
y Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 e of death 5	Other (specify)		23e. Did toba		Day Year		
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State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

9801 Georgia

30. Name and address of pason who completed cause of death (Item to Type,

Merlyn Vemury, M.D.,

D35791

Avenue, #227, Silver Spring, Maryland 20902

October 29, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie () [34532 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3^{Day} 2004 October 28, **Physician** John Edwin McKeever 6:35 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** National Lutheran Home Rockville Montgomery 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1ÑM 2□ F Yrs. 163-05-9358 90 0klahoma Director 1914 April 10, Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits il Hygiene. other then "natural", or Items 23a or 28a-f show vent, the Medical Exprimer must be notified at 1 X Yes 2 □ No Maryland| Montgomery Rockville Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Veirs Drive 20850 United States Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White ğ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 18b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Real Estate Development Elementary/Secondary (0-12) College (1-4or 5+) and Marketing Realtor/Developer 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other treumetic event 2008. 17. Father's Name (First, Middle, Last) Be Jesse Alexander McKeever Lucille Egan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patrick C. McKeever/son l Tanager Court, Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 29, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium 2004 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase 1nc. 7557 Wisconsin Ave., Bethesda, Maryland 20854 21. Signature of Funeral Service Licenses William a. You M01173 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Do not enter the mode of dying such as cardiac or respiratory Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner use as the burial-transit Physician: The law requires that the death certificate be executed v the attending physician and Due to (or as a consequence Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 2 No 1 🗌 Yes 2 1 No 1 Tes After this certific funeral director, 25. Was case referred to medical examiner? Certification; To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation М 2 Accident after death completely filled in by the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

Registrar

State

Charles Karesh, M.D.

31. Date filed (Month, Day, Year) NOV 1 - 2004 32. pegistrar's Signature

9701 Veirs Drive, Rockville, MD

			1- State Amend Items 7,	ate of Maryland / C 8 per DVR, G845	epartment of learning of learn	lealth and Me Beath	ental Hygie	2001	+ 34533
	Physic	aian	1. Decedent's Name (First, Middle, Last)				2. Date of Death		3. Time of Death
	/Med	ical	Georgia Od 4a. Facility Name (If not institution, give street		leadows		October		004 8:45 AM
	Exam	iner	Suburban Hospital	and number)		r Location of Death thesda		4c. County of I	gomery
	Funera		5. Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) If Under 1 Year		3. Date of Birth (Month, Day, Y		Birthplace (State or Foreign
	Directo		577-34-9471 1□M 3	75 84	Yrs. Months Days	Hours Min.	Sept. 1	4, 1920	Virginia
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	Mary a-f sh	tor	Maryland Montgomer	у	Bethe	sda			1 □ Yes 2 □ No
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Modical Evantinal must be indiffed at	al Director	10e. Street and Number 5721 Grosvenor Lan	e	10f. Zip Code	20814	100	g. Citizen of Wha United	•
	r deat	Funeral	A	as Decedent Ever in U.S. med Forces?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Speci an, Mexican, Puerto Ri	ify Yes or No- ican, etc.)		American Indian, White, etc.
	36 rs afte	by Fi	If	☐ Yes 2 [X]No Yes, Give ear or Dates:	1 ☐ Yes 2 🛣 No	Specify:		Specify:	Black
	5-00		15. Decedent's Education (Specify only highest grade com	nleted) 16a.	Decedent's Usual Occup (Give kind of work done)	ation	16	3b. Kind of Busin	ess/Industry
	Athin han "re	Completed	Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. DO NOT use retired	1)		Own	Homo
	d 2. Hilled v Hygie ont, in		12 17. Father's Name (First, Middle, Last)		Homen	18. Mother's Name (First. Middle, Ma		nome
	land be Mental	To Be	Henry	Scott		Susan		Jacks	on
	Maryland 21215-0036 to 2 should be filed within 72 hours aft th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, tre Madical Event traumatic event.	7.9	19a. Informant's Name/Relationship (Туре, Р. Leonard Kelly / Gu		Mailing Address (Street 535 13th St		Route Number, C		te, Zip Code) 20010
	Baltimore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 ☐ Remov		Disposition (Name of y, crematory or other place	Dai		c. Location - City	y or Town, State
	Lime Fage treent tant: If		'4 □ Donation 5 □ Other (Specify)	1 .	eake Cremat		0/04	Belts	ville, MD
S	Ball permit Depar Impor		21. Signature of Funeral Service Chappee	M00382	Ran Fune	ss of Facility ral and Cr Ave., Silv	emation er Sprin	Service	s 20910
577	BEE	ř	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one call	s that caused the death. Do n	not enter the mode of dyin	ig, such as cardiac or	respiratory arres	t,	Approximate Interval Between
8	Physician	_	Immediate Cause (Final disease or condition	SEI	0515				Onset and Death
	/Medica Examine		resulting in death)	Due to (or as a consequence of		A CT	FFF	1011	
_		je l	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence of	ARY TRI	ter in	PCLI	102	
20 1	nd rransit	Examiner	that initiated events c	PNE	UMONI	A			
101 8z	8760, cate be exemply sician a	a E	resulting in death) Last	Due to (or as a consequence of	01):				
0	ox 687 certificate ding phys	edical	d						
7	Box sath cert attending for use a	an/M	230. was decedent pregnant	yes, outcome of pregnancy □Live birth 2 □ Fetal death	3 Ectopic pregnancy			23d. Date of	•
	. 5 6 5	Physician/Me	in the past 12 months?	Pregnant at time of death Unknown	5 Other (specify)			Month	Day Year
I	ds, P. (ires that the signed by detac		Part II. Other significant conditions contribut	ing to death but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	cco use contribut	e to the cause of death?
23	Records, P.O he law requires that the shas been signed by thing 2 should be detached.	ed by	LUN	CANCE	R		1 ☐ Yes	20 No 3	Probably 4 Unknown
5	as b	Completed					24a. Was an autopsy	24b. Were	autopsy findings available to completion of cause of
9	_ F # 6	Con					performe	d? deat	h? Yes 22 No
	of Vital Re Physician: The this certificate ha	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: 1.☑Inpatient 2□ER/Out	Oth	26. Place of Death (
Z	g Phy er this	}-	27. Manner of Death 28	a. Date of Injury 28b. T	ime of 28c. Injun	er: 4 Nursing Home	d. Describe how		Specify)
2	sion ending eath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day 19al)		Yes 2 □ No			
20	Division of a lor Attending Physical death. Director: After this in by the funeral di	Certification;	3 Suicide 6 Could not be 4 Homicide determined 28	e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28	f. Location (Stree City or Town, S	et and Number o State)	r Rural Route Number,
Meadows	spital hours a ineral y filled		29a. Certifier Certifying Physician	: To the best of my knowledge	, death occurred at the tin	ne, date and place, and	d due to the caus	se(s) and manne	r as stated.
2	Division of To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this a completely filled in by the funeral direction of the funeral direction.	Medical	one) a	on the basis of examination and manner stated.					
	To Your	2	29b. Signature and title of certifier	Ban M	29c. License			. Date signed (M	
	1	2	30. Name and address of person who complete	ed cause of death (Item 23a) (Type, Print)	4=-	7	(012	8104
				D: 13219 E	XECUTIVEPO	RK DR: G	ERMA	STOUN	8104 MD 20874
		tate	31. Date filed (Month, Day, Year) NOV 1 = 2004	32 Registrar's Signature	fro. V	,			
	Regis	तावा	1101 1 2 2007	100	Mount				

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 34534 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Year MARINO Augelo, 1 00 PN 10 ZQ04 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltilline If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1√2 M 2□ F Director 216-18-4895 83 January 25 1921 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exactions must be notified at 1 ☐ Yes 2 ☐ No Maryland Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 6918 Delvale Place 21222 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inforbant: if item 27 is marked other than "natural", or iten way injury or other traumatic event, it a Medical Ever it at 9008. 1 ☐ Yes 2 ☐ No tf Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No δ 3. Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Hemmingway Trucking NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marino Rose Bocotta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>Patricia Carson (Niece</u> 6918 Delvale Place Baltimore, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Heart of Mary Dundalk, Maryland * 4 ☐Donation 5 ☐ Other (Specify) 5,2004 21. Signature of Funeral Service 22. Name and Address of Facility Funeral Homes P.A. W Dabrowski/Chojnacki Funeral Homes P.A. 1005 Dundalk Ave. Baltimore, Maryland 21224 23a Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Shock Physician /Medical Due to (or as a consequence of): Examiner Lugemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 DEctopic pregnancy Month Day Year 4 Pregnant at time of death signed by the at d be detached fo 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 2□ No 1 ☐ Yes Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 9 To the Hospitel within 24 hours a To the Funerel L 29a. Certifier 1 🖍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature, and title of certifier 10-29-04 KES-000 Ũ 30, Name and address of person who completed cause of death (ttem 23a) (Type, Print) Michael Elestein, Avenue, Baltilucre, MD, 21224 Easteru THRMC 4940 31. Date filed (Month, Day, Year) NOV 0 1 32 Registrar's Signature State 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registre Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OhNS TOPKINS If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 M 2 ☐ F Yrs. Director 060-28-9653 80 03/24/1924 China Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits works ir than "natural", or Itams 23a or 28a-f shov the Mudical Examiner must be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21122 8502 Jenkins Road death Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. ò 3 Widowed 4 Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nt any injury or other traumatic evant, I.a. Mudic 2006. (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Business Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Harry H. King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7810 Poplar Grove Road, Severn, MD 21144 William Ng/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mm Pk 11/01/04 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility G. J. Gonce Funeral Home, 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear/failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (evv **Physician** <u>day5</u> umatic /Medical Due tq (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has le 2 page certificate 1 Yes 2 XNo To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 No 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 2 this : After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Diractor: 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral C 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of contitier MO mo of death (Item 23a) (Type, Print) 30. Name and address of person) Wolfest CA 31. Date filed (Month, Day X 2004 Regil ar's Signature State Registrar

			Please	Type or Print in BI State of Maryland							01506
		•	For State Registrar	State of Maryland		tificate of			Reg. No.	004	34536
P	Dhuaisi		1. Decedent's Name (First, Middle, Las		_			2. Date of Dea		Year	3. Time of Death
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	Examin	er	4a. Fecility Name (If not institution, give	street and number) ROA	ed	4b. City, Town, o	r Location of Death		PAJM	inty of Deeth	eures
h	Funeral		Social Security Number 6. S	7. Age (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt	h	9. Birtho	lace (State or Foreign
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	n 72 hours after death with the Marylan "neturel", or itama 23a or 28a-1 ehow idical Examiner musi be nollited at	Funeral Director	10e. Street and Number	- DJ		10f. Zip Code	20705		_	of What Cour	-
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(0	ritam ritam	Fun	Marital Status Never Married 2 Married	Armed Forces? 1XXYes 2 \sum No If Yes, Give	If	Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, White,	
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215-0036	within 72 hours after death with the Maryland ene. then "naturet", or itama 23a or 28a-1 ehow he Medical Examiner must be nutilled at	Completed	15. Decedent's Ed (Specify only highest gra		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of worki	n <i>g</i>	16b. Kind o	of Business/Ind	dustry
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Mar	d 2 sh th and 7 to m traum		19a. Informant's Name/Relationship (1) Linda Good / Date				and Number or Rura t., $Belts$			wn, State, Zip 2.0705	Code)
	Health tem 27 othar tra		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of)ate		on - City or To	wn, State
m0	Pages nent of 1 int: if it		1 ☐ Burial 2 XXX remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Choc		atory or other place Cremato		6/04	Ве	ltsvil	le, MD
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natur any injury or other traumatic event, the Medical ODGS.		21. Signature of Funeral Service Licen	see	22 R	Name and Addre	ess of Facility ral and Cr	emation	Serv	ices	
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Division	after d Direct in by	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	1			City or Tox	Street and Nu	Imber or Rura	TRoute Number
	To the Hospital or Attanding Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director.	al Ce	29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowl	ledge, death	occurred at the ti	me, date and place,	and due to the	cause(s) and	manner as st	ated.
	he Ho in 24 l he Fu pletely	edical	(Check only 2 Medical Examone)	niner: On the basis of examination and manner stated.	on and/or inv	estigation, in my	ppinion, death occurr	ed at the time,	date and place	ce, and due to	the cause(s)
	To t To t com	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sig	gned (Month,	Day, Year)

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SALVADOV SylvyTev, 3c or Hospital

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004

	4 Decedents Name (Proce 44) 4	I net)	00,	rtificate of	Dodin		leg. No.	004	T (B ::
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Hygiene. ther than "natural", or items 23s or 25s-f show ent, the Medical Examine must be notified at e Completed by Funeral Director	3026 Birdview Rd			21157			nited S		
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Hea ten	20a. Method of Disposition		20b. Place of Dispo	sition (Name of			20c. Location ·		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 34538 State of Maryland / Department of Health and Mental Hygie e 1 Certificate of Death 2. Date of Death Month 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** October 28, 2004 8:25A PLUNKETT MARGARET MARY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 3738 Beech Avenue Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 97 February 25,1907 Director 213-05-4939 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 27 is marked other than "natural", or Itema 23a or 28a-f show treumatic event, the Medical Exacts or most be collified at XXYes 2 No Director Maryland N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 USA 3738 Beech Avenue death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes & M No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status permit. Pages 1 and 2 should be itied within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Item any injury or other treumatic event, the Medical Exert in all 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify White 3 X Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas E Grogan Sarah Brannan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 40 Dunkirk Road Baltimore, Maryland 21212 DTR Margaret M Bauersfeld 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3 Removal from State Dulaney Valley Mem Gar 11/1/04 Timonium Maryland ♠ ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Se 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pancreatic Cancer months **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Due to (or as a consequence of): Examiner death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 TYes 2 No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an has 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 2 ER/Outpatient 3 DOA s after death.
I Director: After this
of in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral C To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier min houm, us 00056156 October 28, 2004

DHMH 17 Rev 1/2001

State

Registrar

Suzanne Caccamese MD 6565 North Charles Street Towson MD 21204 Suite 203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

31. Date filed (Month, Day, Year)

NOV 1 -

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] [] 34539 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Oct. 26 2004 Anna Elizabeth Price 9:05pm /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Havre de Grace Harford 114 Seneca Avenue 8. Date of Birth (Month, Day, Year) 01/07/1923 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🖫 F 81 Marylánd Director 215-18-8960 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28a-f show the Medical Examiner must be indiffed at 1XYes 2 No Director MD Harford Havre de Grace 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 114 Seneca Avenue Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) 10th Homemaker Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othreny injury or other traumatic event, once. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alfred Kennedy Gertrude Weisentol 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 Seneca Ave., Havre de Grace, MD 21078 Joan Deal- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Harford Mem. Grdns 10/29/04 Aberdeen, MD 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. ware 123 S. Washington, Havre de Grace, MD 21078 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronany lours **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy 1 Live birth in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dialist Of Mellus Rend Feeling 23e. Did tobacco use contribute to the cause of death? Completed by cullivre 3 ☐ Probably 4 ☐ Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 has certificate 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Yes this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

the death certificate be executed P.O. Box 68760. Division of Vital Records, or Attending death. hours after death unerel Director: A ly filled in by the fi within 24 hours a To the Funerel L

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

completely

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Medical

4 Homicide

29b. Signature and title of certifier

Kammolin

29a. Certifier

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Winan



Milhami MD 21078

ma

1100 RevolutionSt +

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signad (Month, Dey, Year)

MD 21078

avre De Grow

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney 34540 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** OCTOBER 10:30F M 8. 2004 Mary Doris Ports 1 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Joseph Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. July 1923 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 □ M **X**XF Months 81 Yrs. Maryland 212-20-4047 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location works ! 10a. State 10b. County tems 23a or 28a-f shore 1 ☐ Yes 🏋 No Funeral Director Reisterstown MD Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 Sacred Heart Lane U.S.A. 21136 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examinant Black, White, etc. filed within 72 hours after 1 ☐ Yes 🏋 No If Yes, Give Year or Dates: 1 Never Married Married 0 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify. Specify: Be Completed by White 3 Widowed 4 Divorced 'naturel' 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) Il Hygiene. Homemaker Own Home 7 Is marked other traumatic svent, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill timent of Health and Mental H tent: If item 27 is marked oth jury or other traumatic even John Bernard Deters Mary Jane Nowell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Norman L. Ports / Spouse 108 Sacred Heart Lane; Reisterstown, MD21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. Garrison ForestCem 11/3/04 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Fin Tal Service Licensee 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DNE DAY SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner TWO DAYS PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. E. ter condensitying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last physician ar s the burial-ti Due to (or as a consequence of): Box 68760. Physician/Medical ast attending p IF FFMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Records, P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown MYOCARDIAL INFACTION Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform 1 ☐ Yes certificate 2 No 1 ☐ Yes Division of Vital or Attending Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 Yes 287 No this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After Injury 1 Natural 5 Pending safter death. 1 Tes 2 No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 53464 30. Name and ad ss of pers in who completed cause of death (Item 23a) (Type, Print) 6.17(1) OSLER DRIVE TOWSON MARYLAND 21204 MARX 1/1 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MOV 1 - 2004 Registrar

			For State Registrar	State of Maryland	I / Department of Health and Certificate of Death	d Mental Hygier Reg. t		34541
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Prau		2. Date of Death Month	Pay Year,	3. Time of Death
	Examin		4a. Facility Name (If hot institution, give s	venue	4b. City, Town, or Location of De		4c. County of Death).
	Funeral Director		5. Social Security Number 6. Sex Usual Residence of Decedent	M 2DF 7. Age (In yrs. la	st birthday) If Under 1 Year If Under 24 H Months Days Hours M	in. (Month, Day, Yea	ar) 4 9. Birthp Cour	place (State or Foreign
	Maryland f show	or	10a. State 10b. County	10c. City,	Town or Location		1	0d. Inside City Limits
	with the ha or 28a-	Director	10e. Street and Number	Avenua	10f. Zip Code	10g. (Citizen of What Cour	ntry?
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural" or items 23a or 28a-f show or other traumatic event. The Madical Examiner mat be muffled at	by Funeral	11. Marital Status 1 Newer Married 2 Married 3 Wildowed 4 Divorced	2. Was Decedent Eventh U.S. Armed Forces? 1	i. 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 Yes 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White, Specify:	
21215-0036	nin 72 hour In "natural Medical Ex	Completed t	15. Decedent's Educ (Specify only highest grade	ation	16a. Decedent's Usual Occupation (Give kind of work done during most of v life, DO NOT use retired)	vorking 16b.	. Kind of Business/Inc	dustry
	e filed with Il Hygiene other the	Ве Сош	17. Father's Name (First, Middle, Last)	NA	Humemaker 18. Mother's N	lame (First, Middle, Maid	DMESTIC lea Sumame)	
Maryland	should be and Mental s marked c umatic eve	ToB	Irvin Jenkins 19a. Informant's Name/Relationship (Type)	oe, Print)	19b. Mailing Address (Street and Number or	SSC N Rural Route Number, City	y or Town, State, Zip	Code)
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importants: if item 27 is marked other than any injury or other traumatic event. If a MODG.		Ellen Locumi 20a. Method of Disposition	Cor	ace of Disposition (Name of metery, crematory or other place)	Arbutus, 1)	Location - City or To	27 own, State
Baltimore,	permit. Pages Department of I Important: If it any injury or o		1	emoval from State Mox	untlawn 11	aughn C. Gre	hibdelphio	L PA :
Ä	permi Depar Impor any ir		23a. Part1. Enter the disease, or complie	cations that caused the death.	Do not enter the mode of dying, such as card	d, Ramal6 iac or respiratory arrest,	tous, Mil	2/133 Approximate Interval Between
l	Physician /Medical	8	Immediate Cause (Final disease or condition resulting in death)	1	NCER			Onset and Death
8760,	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, and the course in the runderlying Cause (Disease or injury that initiated events resulting in death) Last	Metastaci	es to BRAIN			
O. Box 6	ath certifi ittending or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Bc. If yes, outcome of pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea 9□Unknown	death 3 ☐ Ectopic pregnancy		23d. Date of delive Month	ery Day Year
<u>α</u>	uires that the de signed by the a id be detached f	by	Part II. Other significant conditions con	tributing to death but not result	ting in the underlying cause given in Part I.	23e. Did tobacci	o use contribute to the	
Il Records,		Completed				24a. Was an autopsy performed 1 Yes 2	prior to cor death?	psy findings available mpletion of cause of 2 \(\text{No} \)
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ E	Othor	eath (Check only one) Home 5 Residence	6 Other (Specific	v)
ion of	fing After fune	 	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of	28d. Describe how in		
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical (29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowner: On the basis of examination and manner stated.	fiedge, death occurred at the time, date and pla on and/or investigation, in my opinion, death oc	ice, and due to the cause curred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	uluo MO	29c. License number		Date signed (Month,	
	18		30. Name and address of person who co	mpleted cause of death (Item 2		(A) G (1 00-20	MD 21041
	Sta Regista		31. Date filed (Month, Day, Year) 200		1 edical Hets Build	1109,000	WANDIO	I D ZIOTT

		•	1 - For State Registrar	State of Mar	ryland / Depa <i>Cei</i>	artment of Healt rtificate of Dea	th and Mental Hy	ygien 004	34542
	Physici /Medic		Decedent's Name (First, Middle, Las SHA)	RON J.	RICHA	RDSON	2. Date of D Month OCTOBE	A Day Year	3. Time of Death 12:27 PM
	Examin		4a. Facility Name (If not institution, give	DICAL C	enter	4b. City, Town, or Locat	MORE	4c. County of Dea	ath
	Funeral Director		5. Social Security Number 6. S 211 • 14 • 1864 Usual Residence of Decedent	ex 7. Age ((In yrs. last birthday) 47 Yrs.	If Under 1 Year If Un Months Days Hou	nder 24 Hrs. Irs Min. 8. Date of B	irth Pay, Year, Sto M	rthplace (State or Foreign during) HKY LAND
	Maryland -f show	tor	10a. State 10b. County	1	10c. City, Town or Lo	MORE			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 4804 /2 (RE)	NSHAW 1	Art.	10f. Zip Code	720U	10g. Citizen of What C	country?
980	72 hours after death with the Maryland natural; or items 23a or 28a-f show Jisal Examinant has be calified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent EV Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	1	Was Decedent of Hispanic f Yes, specify Cuban, Mex 1 ☐ Yes 2 ☑ No Specify	o Origin? (Specify Yes or Nican, Puerto Rican, etc.)	lo- 14. Race - Am Black, Wh Specify:	
21215-0036	within ene. than "	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during in DO NOT use retired)	most of working	POST A	s/Industry SERVICE
Maryland		To Be (17. Father's Name (First, Middle, Last) ERIC J	ONES		18. M	CARRIE	e, Maiden Sumame) BUUIG	Y
	s 1 and 2 should f Health and Mer lam 27 is marke other traumatic		JAMES A. KICHA	Type, Print) ROSON HUSE	MND 480	4 /2 CREN	SHAWAF.	BAUTO, MC	21206
Baltimore	Pages 1 nent of F ant: If its ary or ot		20a. Method of Disposition 1	v)	CEDAR H	sition (Name of natory or other place) UENETER	10.30.04	BATIMIRE	T, MARYUND BAUD, MO
Bal	permit. Pag Department Important: any injury o	10	21. Signature of Funeral Service Licen	he Green	e \(\frac{22}{V}	AVGHN C.	GREENE TV	NERAL HO	NE 21212
1	Pnysician /Medical		23a. Part1. Enter the disease, or constant shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line.	ASTATIC	er the mode of dying, such	110111	arrest, GANCEL	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	consequence or):			0	
,0928	sate be executed physician and the burial-transit	ai Examiner	Sequentially list conditions, if any, leading to initialist cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as a c	consequence of):				
Box 687	ath certific attending p for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir	Fetal death 3	Ectopic pregnancy		23d. Date of de Month	elivery Day Year
P.O.	that the de ed by the detached		1 ☐ Yes 2	9☐ Unknown			ant. 23e. Did	tobacco use contribute t	o the cause of death?
Records,	The taw requires that the site has been signed by the page 2 should be detache	leted by					1 X		robably 4 Unknown
al Re		Completed	25 W				auto per 1 Yes	ormed? prior to death? 1 Yes	completion of cause of
of Vital	Physiclan: this certific ral director.	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient		t 3 DOA Other: 4	Nursing Home 5 Res	idence 6 Other (Spe	ecify)
Division	ath. or: After ne fune	Certification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be			Work? M 1 ☐ Yes 2	2 No	how injury occurred	
Divi	i Dig		4 Homicide determined	building, etc.	y - At home, farm, str (Specify)		City or To	(Street and Number or Rown, State)	
	To the Hospital within 24 hours a To the Funaral completely filled	Medical	(Check only 2 Medical Examone)	niner: On the basis of e and manner state	xamination and/or in ed.	estigation, in my opinion,	e and place, and due to the death occurred at the time	, date and place, and du	e to the cause(s)
)	To Too	2	29b. Signature and title of certifier	Qualue	1	29c. License numb	94 Baltim	Oct 29.	th, Day, Year)
1	B		30. Name and address of person who who was the same and address of person who was the same and t	completed cause of dea	Philadal	DAIA RD #31	4 Bolton	IDNE 212	37
	Sta Registr		31. Date filed Monty, Thy, Year 3004	32 Registrar	s Signature	Looks			

		_	1 - For Amend Ite	State of Marylan 27,28a-f per	nd / Department of ME 6837 11/0	Health and Ment	al Hygiene	2004	34543
	Plusia		1. Decedent's Name (First, Middle,	Last)			ate of Death	y Year	3. Time of Death
	Physici /Medi		Helen Mari				0 /7	2004	8:40 PM
	Examir	ier	4a. Facility Name (If not institution, FANKIN S 5. Social Security Number	guare Hos	4b. City, Town Ast birthday) If Under 1 Yea	s e da le		BALL	imore
	Funeral Director		218-18-4852	1□ M 2♥ F 87	Yrs. Months Day		ate of Birth fonth, Day, Year)	Cou	place (State or Foreign intry) aruland
	p ,		Usual Residence of Decedent 10a. State 10b. County	100.0	ity, Town or Location			710 ; M	
	deeth with the Maryland me 23s or 28s-1 show r nust be mallised at	tor		ultimore	Balti	ma h a			10d. Inside City Limits 1 ☐ Yes 2 No
	or 28a	lrec	10e. Street and Number	adilote	10f. Zip Code		10g. Cit	tizen of What Cou	intry?
	eth wil	rai	8620 Kelso Dr.,			221		U. S. A	
36	within 72 hours after der ene. than "natural", or fteme re Micola Estruller n	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	J.S. 13. Was Decedent of If Yes, specify Control of Image in the Image	f Hispanic Origin? (Specify Y uban, Mexican, Puerto Rican lo Specify:	'es or No- , etc.)	14. Race - Ameri Black, White Specify:	
26	72 hou		15. Decedent's (Specify only highest	Education	16a. Decedent's Usual Occ	supation ne during most of working	16b. K	(ind of Business/li	
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d 2	be filed withintal Hygiene. Ind other than event, the M	CO	8th Grade 17. Father's Name (First, Middle, L.	ast)	Sales C	18. Mother's Name (Firs	t. Middle, Maiden	Candy	
Maryland		To Be	John Mordecai				E. Raun	•	
lar	9 = 9		19a. Informant's Name/Relationshi			et and Number or Rural Rou	te Number, City o	or Town, State, Zi	
_	s 1 and 2 should f Health and Mer fem 27 is marke other treumatic		Joseph Chamberlo 20a. Method of Disposition		937 ELton Av	e., Baltimore	, Maryla	and 21224 ocation - City or T	own State
Baltimore,	8 ° = 5		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	3 □Removal from State	cemetery, crematory or other p	* 1			
aĦ	permit. Par Departmen Importent: any Injury once.		21. Signature of Funeral Service Li		22. Name and Ado	10/21/20 tress of Facility Schil		remore, ineral He	
Ä	Depar Impo any Ir		fame	Jeg !	9705 Bel	ain Rd Ralt	imano N	lanuland	
	Pnysician /Medical		23å. Part1. Enter the disease, or c shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	complications that caused the deanly one cause on each line. a	Failure	ying, such as cardiac or resp	piratory arrest,	Ty Cy	Approximate Interval Between Onset and Death
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Ć,	cate be executed physicien and the burial-transit	Exan	that initiated events resulting in death) Last	c Due to (or as a conse	quence of):	AXX A	4.		
8760	icate be e physicien s the buria	dicall		d			Carried V		
9		63	IF FEMALE:		-36	1/50			177
P.O. Box	The law requires thet the death certificate has been signed by the attending tragge 2 should be detached for use as	ysiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 Ectopic pregnar			23d. Date of deliv Month	ery Day Year
	w requires thet been signed t should be det	ed by Physi	Part II. Other significant condition	s contributing to death but not re	sulting in the underlying cause	given in Part I. 2	3e. Did tobacco u 1 ☐ Yes 2		he cause of death?
Records,	The law recate has bee page 2 sho	Completed					4a. Was an autopsy performed? ☐ Yes 2 ☑ No	death?	opsy findings available impletion of cause of
Vital	eiclen: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hamitali		26. Place of Death (Che	ck only one)	- 0.1	
of	Phyer r this c	P.	1 Yes 2 No 27. Manner o De	Hospital: 1 In Inpatient 2 I	JERVOUIDALIBITE 3 DOA	Other: 4 Nursing Home 5	Residence		(y)
lon	Attending Physiclen: r death. securities ector. After this certifies by the funeral director.	atlon	7 Accident 5 Pending investiga	(Month, Day Year)	Injury W	lork?` □Yes 2√⊋No fe		standing	<u>r</u>
Division of	r Attencer death rector: by the	Certification;	3 Suicide 6 Could no 4 Homicide determin		nome, farm, street, factory, officity)				
	oftel or urs efte rel Dire		Acciden'	Residence -	- Apartment	86	TO VETPO	DL., AL	D В В В В В В В В В В В В В В В В В В В
	To the Hospitel or Attentwithin 24 hours efter deatl To the Funeral Director:	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examin and manner stated.	owledge, death occurred at the ation and/or investigation, in my	time, date and place, and du popinion, death occurred at t	ie to the cause(s) he time, date and) and manner as s d place, and due t	stated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	N	29c. Lice	nse number	29d. Dat	te signed (Month,	Day, Year)
	-		1 grea	Sono	BF	500000	101	17/04	
			30. Name and address of person w	to completed cause of death (Ite	m 23a) (Type, Print)		0 1		11
	Sta	ate	31. Date filed (Month, Day, Year)	AVAX 9000 32. Registrar's Sign	TROAKIN S	BUALC DIVE	150(+)m.	ure mo	e 21237
	Regist		NOV 1 - 200		& Sparks	SOOOO			

State of Maryland / Department of Health and Mental Hygier 00 [4 34544 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First Middle Last) Month Day **Physician** 5 - 42 AM Charles E. Royster th 200H /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore NA Union Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-20-1923 5. Social Security Number 6. Sex 1X M 2 ☐ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** North Carolina 80 Director 223-20-3288 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State tem 27 is marked other than "naturel", or Itams 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at Baltimore 1X Yes 2 No NA Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code With 21207 IISA 5610 Belle Avenue death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene.
Is marked other than "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sugar Refinery Bulk Loader 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine Downing Berl Royster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 sl nent of Health and ent: If Item 27 Is r Sallie R. Royster/Wife 5610 Belle Avenue Balto, MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages:
Department of H
Importent: If Ite
any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-01-04 Baltimore, MD Baltimore Nattional Cem. * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Wylie Funeral Home 638 N. Gilmor St. Ralto, MD 21217 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** hows disease or condition resulting in death) ulmonary mho /Medical Due to (or as a consequence of)) **Examiner** ESRD 4 eaus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed VF Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical ears IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has b page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 240 To the Hospitel or Attending Physiclen: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 2 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28d. Describe how injury occurred Certification: After (Month, Day Year) 5 Pending investigation Natural М 1 ☐ Yes 2 ☐ No death. Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier ical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AT2438946 oct 27th, 2004 havan am Velsakar MD 201, EAST UNIVERSITY PARKWAY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOWRI. VEERARAGHAVAN BALTIMORE, ND 21218 31. Date filed (Month, Day, Year) 32 Registrar's Signature State March St Sports Registrar NOV 0 1 2004

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 34545 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 23, 2004 **Physician** 8:34 PM Romero. Sr. Juan Kamon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Washington Adventist Hospital Takoma Park Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | March | 3, 1943 | Puerto Rico 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 61 Yrs. 582-72-4335 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deportment of Health and Mental Hygiene.
Importent: If item 21 is marked other then "natural", or Itams 23a or 28a-f show any njury or other treumatic event, 112 Mydical Examinations in the provided one. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Tyes 2 XNo Maryland Prince George's Hyattsville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7704 Adelphi Rd. 20783 United States #33 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1♥ Yes 2□ No Specify: Puerto Rican Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ₺ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) (Unavailable) (Unavailable) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Rodriguez Ramon Romero 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7704 Adelphi Rd. #33; Hyattsville, MD Juan Romero, Jr. / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crematory 10/28/04 Beltsville, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final sephic DA Physician disease or condition resulting in death) /Medical Due to (or s a consequence of) Examiner Due to (or as a consequence of): imoms Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Division of Vital Records, P.O. Box 68760, Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 5 ☐ Other (specify) ⊒Yes 2□No ed by the a 9 Unknown has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Yes 2□ No certificate 1 Yes 2 X No To the Hospitel or Attending Physician: 26 Place of Death Check only one 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 0 1 ☐ Yes _ 2 🔀 No 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: After Injury 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide within 24 hours a

To the Funerel Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and otle of certifier D45660 10-26-65 Boule MD 20715 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Car, My 3 (D) 14300, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 1 - 2004 Registrar

		1	For State Registrar	State of Maryland / Dep Ce	partment of Health and Nertificate of Death	Mental Hygie Reg.		34546
	Physicia	_	I. Decedent's Name (First, Middle, Last)	RANDOLPH		2. Date of Death Month	Day Year 26 2004	3. Time of Death
	/Medic Examin		la. Facility Name (If not institution, give s	treet and number) , CENTER	4b. City, Town, or Location of Death BALTIMERE		4c. County of Death	
	Funeral Director		212-20-659	M 2□F 7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo	9. Birth Con 25 M	nplace (State or Foreign intry)
	aryland show		Usual Residence of Decedent 10a. State 10b. County NA	10c. City, Town or Bait				10d. Inside City Limits 1 XYes 2 ☐ No
	th the Ma or 28a-f	Directo	10e. Street and Number	•	10f. Zip Code	10g	. Citizen of What Co	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Important: If Item 27 is marked other than "natural", or Items 25a or 28a-f show important: or other traumatic event, the Medical Evant of must be notified at 2008.	Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U.S. Armed Forces?	3. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White	ncan Indian,
5-0036	thours after	by	3 Widowed 4 Divorced	reation 16a. Dec	1 ☐ Yes 2 ☑ No Specify: cedent's Usual Occupation ve kind of work done during most of wo.	rking 16	Specify: B	Industry
21215	d within 72 piene. r than "ne the Medic	Completed	(Specify only highest grade	College (1-4or 5+)	enterior Decor	ator		nprovement
Maryland 2121	uld be filed fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Robert Raw	dolph	Doro		daiph_	
Mary	nd 2 shoualth and M 27 is mai		19a. Informant's Name/Relationship (7) Chur lotte R.	pe, Print) 19b. Ma	ailing Address (Street and Number or Richard Av	e Baltim	rere, MD	21215
Baltimore,	Pages 1 a nent of Hez nt: If Item rry or othe		20a. Method of Disposition 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify)	cemetery c	sposition (Name of strematory or other place) The Forest Vet Nev	1,2005 R	Saltimar	e Mary bud
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens Rencel Cl	Trayser	22. Name and Address of Facility Remarks A GRMS	virin Av	ral Hame re Balt	m021201
	Pnysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the death. Do not ne cause on each line. ACUTE RESPIRA		c or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				ONE DAY
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):				
8760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
Box 6	ath certific attending p for use as	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of de Month	livery Day Year
ds, P.O	uires that the de signed by the a id be detached	by	Part II. Other significant conditions of	ontributing to death but not resulting in th	ne underlying cause given in Part I.			o the cause of death? robably 4 □Unknown
Records,	ne law requir s has been si ge 2 should	Completed	COPP			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	icl an : The lav certificate has rector, page 2	Be Co	25. Was case referred to medical examiner?	Hospital:	Other -	eath (Check only one	9)	
of	ng Phys ter this neral dir	Ilon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	ne of 28c. Injury at	28d. Describe how	nce 6 ⊡Other (<i>Spe</i> w injury occurred	успу)
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: All completely filled in by the fu	Certification:	2 Accident 3 Suicide 4 Homicide		n, street, factory, office	28f. Location (Str. City or Town,	eet and Number or R , State)	Rural Route Number,
	Hospita 24 hours Funeral itely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exam	ysician: To the best of my knowledge, on the basis of examination and/	death occurred at the time, date and pla or investigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To the within ?	Med	29b. Signature and the of certifier	domo- Lu	29c. License number		ed. Date signed (Mon	
	, 11		30. Name and address of person who	INTERNAL MEDIUS completed cause of death (Item 23a) (T), MD 3001 S. HAN	NE Print)			
	S	tate	31. Date filed (Month, Day, Year) NOV 0 1 2004	32. Registrar's Signature	W	,		

State of Maryland / Department of Health and Mental Hygie 20 04 34547

		•	For State Registrar	Certif	icate of Death	Reg. No.	
	Dhysisis		Decedent's Name (First, Middle, Last)	1	1	2. Date of Death Month Day	3. Time of Death
	Physicia /Medic		TOWN TO THE TOWN	IERS, UR.	60 T	10 28	3 04 5.56 PM
*	Examin	er	4a. Facility Name (If not institution, give street and	number)	c. City, Town, or Location of Death	40.	County of Death
	Funeral	_	5. Social Security Number 6. Sex	- M	f Under 1 Year / If Under 24 Hrs.	B. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
	Director		240- 72- 0398 10 M 2 Usual Residence of Decedent	57 Yrs.	ond of our	9-16-4	17 NC
	land ow		10a. State 10b. County	10c. City, Town or Locati	ion		10d. Inside City Limits
	a-f sh	ctor	MD Baltimore	Gwyn	in Oak		1 ☐ Yes 2 D No
	vith the	Director	10e. Street and Number		10f. Zip Code	10g. Cit	tizen of What Country?
	ns 23e	Funerai	11. Marital Status 12. Was I	Decedent Ever in U.S. 13. Was	21207 s Decedent of Hispanic Origin? (Speces, specify Cyban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian,
ပ္	or Her	Fun'	1 Never Married 2 Married 1 Yes	es 2 D/No	es, specify Cuban, Mexican, Puerto R I Yes 2 DV No <i>Specify:</i>	ican, etc.)	Black, White, etc. Specify: 01001
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show Its Madeal Examinar must be notified at	ed by	3 Widowed 4 □ Divorced Year 15. Decedent's Education	or Dates:	t's Usual Occupation	16h K	ind of Business/Industry
215		Completed	(Specify only highest grade complete	ed) (Give kind	d of work done during most of working NOT use retired)		
212	filed with Hygiene. other ther	Com	12th GRADE 6 y	es. Sci	nod Teacher	tal	to. City Schools
and	ould be fil Mental H arked ott atic even	Be c	Kanen W. Sellers	30	Farlang	First, Middle, Maiden	Sumame)
Maryland	should that and Ment is marked burnatic	T _o	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	Address (Street and Number or Rural	Route Number, City o	or Town, State, Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "neturel", or items 23e or 28a-f show item 27 is marked other then "neturel", continer must be notified at		Andre D. Sellers (So	5610	Prince Gerral	St. Gwyn	1 Ook MD 21207
ore	0 0		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal f	com State 20b. Place of Disposition cometery, cremate		70	ocation - City or Town, State
Baltimore,			 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 	Woodla	ame and Address of Facility	the Carpe	re Funeral Service
Ba	permit. Departr Importe any inje		Dhunners	873	& Lubertu Rd Ray	MORESTINA	1, MD 2/133
			23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	nat caused the death. Do not enter to on each line.	he mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician	e i	Immediate Cause (Final disease or condition resulting in death)	Aspiration	V Prayton	A	Onsal and Deam
ı	/Medical Examiner		Du.	a to (or ye a consequence of):	Oystophy.		
	n =	ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of).	To the		
	and I-trans	Examiner	that initiated events C.	e to (or as a consequence of):			
68760,	The law requires that the death certificate be executed to has been signed by the attending physician and page 2 should be detached for use as the burial-transit		d				
	rtificat ng phy s as th	Medicai	IF FEMALE:				
Вох	eath cer attendir I for use	ian/	23b. Was decedent pregnant in the past 12 months?		topic pregnancy ther (specify)		23d. Date of delivery Month Day Year
o.	the de	Physician/		Inknown	triol (opposity)		
S, P	res that the de signed by the a be detached to	by P	Part II. Other significant conditions contributing	to death but not resulting in the unde	erlying cause given in Part I.		use contribute to the cause of death?
ord	w require been si should	eted				-	No 3 Probably 4 □Unknown
Records,	has b	Completed				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
Vital	(0 ===	a	25. Was case referred to medical		26. Place of Death	1 Yes 2 No	1 ☐ Yes 2 No
f Vi	Physician: this certificanal director, i	ToB	examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER/Outpatient	3 DOA Cther: 4 Nursing Hom	e 5 Residence	6 □Other (Specify)
n of	ding Phy n. After thi funeral		i alitatulai S I i olidilig	Date of Injury Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	3d. Describe how inju-	ry occurred
Division	Attending ir death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, street		Bf. Location (Street ar	nd Number or Rural Route Number,
Ο̈́	s after s afte	Certification:	4 Homicide	ouilding, etc. (Specify)		City or Town, State	3)
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	(Check only 2 Medical Examiner: On t	he basis of examination and/or inves	ccurred at the time, date and place, ar stigation, in my opinion, death occurre		
	o the ithin 2 o the omple	Med	one) and 29b. Signature and title of certifier	manner stated.	29c. License number	29d. Da	ate signed (Month, Day, Year)
	r × r o		· Charle 19	hove # 11/16	035330	NO	UBM6122 01
1	Û		30. Name and address of person who completed	cause of death (Item 23al (Type, Pri	nt) A = 0\ 0	lolle i	111 2004
		, i à	31. Date filed (Month, Day, Year)	M. b. 5311 () (32. Régistrar's Signature	dul ho hand	umorciipi	MD 21133
Ī	Sta Regist		NOV 0 1 2004	Been K Rose			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 2004 2:31 PM /Medical 4b. City, Town, or Loceti 4a Facility Name (If not institution, give stre Examiner Year 8. Date of Birth (Month, Day, Year) 1923 9. Birthplace (State or Foreign Country) Social Security Number **Funeral** Days 1□ M 2□xF 80 Alabama Yrs 18 November Director 296-26-8211 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mentel Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28e-f show yell july or other traumatic event, if a Modical Exercise must be notified at Page. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Mitchellville Directo MD Prince George's 10g. Citizen of What Country? 10f. Zip Code 10e Street end Number U.S.A. 20721 10513 Meadowlake Terrace Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Specify: Black 1 ☐ Yes 2 ☐ No Specify: 3altimore, Maryland 21215-0020 δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 3rd Domestic Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Francis Murray Malachi Person 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2072119a. Informant's Name/Relationship (Type, Print) 10513 Meadowlake Terrace Mitchellville, Maryland Curtis L. Smith 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition etery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-30-04 Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses J. B. Jenkins Funeral Home 7474 Landover Road Landover, Maryland 20785 Approximate Interval Between Onset and Death is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical · ATEROSCLERO TIC Examiner Due to (or as a consequence of) Physiclan/Medical Examiner ed by the attending physician and deteched for use as the bunal-trensit Hospital or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. n signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? icate has been sig 7, page 2 should b 24a. Was an autopsy Completed performed? 1 ☐ Yes 2 ☐ No 1 🗆 Yes 2 No this certificate director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 1 Yes Other: 4 Nursing Home Hospital: 2 ER/Outpatient 3 □ DOA 70 2□ No 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) efter death.

Director: After this d in by the funeral d 28d. Describe how injury occurred Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours eft.

To the Funerei Dir

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO05033 my. ho completed cause of death (Item 23a) (Type, Print) 30. Name and address SAYMOND 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 - 2004 Registrar

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 004

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						Certificate	of Death		Reg. No.	•	04043
	Physician /Medical	1. Decedent's Name (First, I Helene	fiddle, Last) SCN	obel				2. Dete of D Month	r 27	2004	3. Time of Death 0530 AM
1	Examiner	4e Fecility Neme (If not inst	tution, give street	end number) & Reh	ab		colur	m, or Locetion of Dea	Hou	sand	
	Funeral Director	5. Social Security Number 273-09-5682 Usuel Residence of Decede	6. Sex 1 M X		n yrs. lest birthe Yr	Months	Year If Under 2 Deys Hours	Min. (Month, D	irth Pay, Year) 7,1918	9. Birthpla Counti Ohio	ace (State or Foreign ry)
	e Maryland la-f ehow ured at	10a. Stete 10b. Co MD How	unty		c. City, Town o						d. Inside City Limits 1 ☐ Yes XX No
	with the Mar a or 28a-1 o be notified	10e. Street and Number	T = = =			10f. Zip C			10g. Citizen of \	Whet Count	ry?
020	s 1 and 2 should be filed within 72 hours aftar death with the Maryland Haalth and Mental Hygiena. Health and Mental Hygiena. Item 27 is marked other than "natural", or items 23a or 28s-f show other traumatic event, the Madical Examiner must be notified at To Be Completed by Funeral Director	6334 Cedar 11. Maritel Status 1 Never Married 2 XXV Widowed 4 Dive	Married 12. W	as Decedent Eve med Forces? Yes XAO No Yes, Give par or Dates:	r in U,S.	13. Was Deceder If Yes, specify	0 4 4 It of Hispanic Origi Cuban, Mexican, No Specify:	in? (Specify Yes or N Puerto Rican, etc.)	USA 14. Rac Blac Specify	ce - America ck, White, e v: Wh	
2-00	72 hou	15. Dec	edent's Education	pieted)	16e. D	ecedent's Usual (Give kind of work	Occupation done during most retired)	of working	16b. Kind of B	usiness/Indi	ustry
21215-0020	ed within 72 ho ygiena. For than "natura it, the Medical Completed	Elementary/Secondary (0		ollege (1-4or 5+)		sewife	retired)		Own Ho	ome	
Maryland	should be filed within and Mental Hygiena. I marked other than umatic event, the Mental To Be Compi	17. Father's Neme (First, Mi	ddie, Last)					's Name (First, Middl ia Baruc		ne)	,
lan	and Name	19a. Informant's Name/Rela	tionship (Type, Pr	int)				r or Rurel Route Num			887576V76V76SDV
Baltimore, N	permit. Pages 1 and 2 Department of Haalth a important: If Item 27 is any injury or other tra phce.	Stephen Sc 20a. Method of Disposition XXBurial 2 Crema	tion 3 □Remov	al from State	cemetery,	cremetory or other	er place)	rt, Elli			
Itim	artmer prtant: injury	4 Donation 5 □Oth 21. Signature of Funeral Se		1/	яшую	National 22. Name and	Address of Fecility	11/04/04	Arlingt	con,	VA
Ba	Pen impo	Melino	16	facel	1	JJJJ IV	ATII VIIO:	Witzke F	COTUMDI	Home:	s, Inc. D 21045
		23a. Part1. Enter the disea shock, or heart failure	e, or complication List only one cau	s that caused the ise on each line.	death. Do no	t enter the mode	of dying, such as c	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
A. C.	Physician /Medical Examiner	Immediate Ceuse (Final diseese or condition resulting in death)	a. A			E POTIC	COR	ONARY A	etery D	KEASE	=
	ed sit	\$	b					- ··· -			
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×	ding sa a	resulting in death) Last	d	Due	to (or as a co	isequence oi).				1	
). Bo	death he atte hed for	Part II. Other significant co	nditions contribut	ng to death but n	ot resulting in t	he underlying cau	se given in Part I.	23b. Die	d tobacco use co	ntribute to	the cause of death?
, P.O.	that the ned by the datach							10	Yes 2X No	3 🗆 Prob	abiy 4 ☐ Unknown
Division of Vital Records,	The law requires that the death of the laten sate has been signed by the attent page 2 should be datached for uncompleted by Physician							24a. Wa	s an autopsy formed?	ava	re autopsy findings ilable prior to apletion of cause eeth?
R	The la							10	Yes 20 No	10	Yes 2□ No
/ita	clen: entific actor,	25. Wes cese referred to m examiner?	edical Hospit	al·			Other:	of Death (Check only			
of	Physician: rthis certific iral diractor,	1 Yes 2 No		a. Date of Injury	2 ER/Outp		4 Nur Injury at Work?	sing Home 5 Re	sidence 6 Oth how injury occur)
on	Attending or death. ector: After by the funa		ending vestigation	(Month, Dey Yo	ea <i>r)</i> Inj	ury M	Work? 1 ☐ Yes 2 ☐ N	lo			
Divis	tal or Attending Pirat death. al Director: After the ind in by the funare Certification:	3 Suicide 6 C	ould not be etermined 28	e. Place of Injury building, etc. (- At home, farr Specify)	n, street, fectory,	office	28f. Location City or T	(Street and Numb own, State)	ber or Rurei	Route Number,
	To the Hospital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificata has complately filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier 1 Ce (Check only 2 Me	dicat Examiner: C	on the basis of ex and manner steted	amination end/ I.	or investigation, in	my opinion, death	place, end due to the h occurred at the time	e, date and place,	and due to	the cause(s)
	To th To th comp	29b. Signature end title of o	ertifier			29c. I	icense number		29d. Date signe	ed (Month, E	Dey, Year)
	/,	Tuly Cl	alyl		MD	D	0060586)	OCTUBER	27	, zwy
	h		TEMPA	ed cause of deet	h (Item 23e) (T	ype, Print) BACK 1	21VER	NEGC R	O BAL	7/MD	et, us
1	State Registrar	31. Date filed (Month, Day,	1 - 2004	32. Registrar's	Signeture	& So	als				

		1	1- State of Maryland / Departr	ment of Health and Men <i>icate of Death</i>	ital Hygiene	004	34550
	Physicia		1. Decedent's Name (First, Middle, Last)	2/12/210 0	Date of Death Month Da	7 7 2 Year 4	3. Time of Death
>	/Medic Examin	al -	4a, Facility Name (If not instruction, give street and number) 4b	. City, Town, or Location of Death	A 4c	. County of Death	1
				uded Care Da	Date of Birth (Month, Day, Year)		N/A lace (State or Foreign
	Funeral Director	<	219-16-0030 12M 20F 79 Yrs. M	onths Days Hours Min.	PRIL 5, 19	25 MA	ZYLAND
	yland sow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	on		1	Od. Inside City Limits
	Ba-f sh	Director	MARYLAND 10e, Street and Number	3ALTIMORE		tizen of What Cour	1Æ(Yes 2□No
	h with t	al Dir	426 WATTY COURT	21201	1	USA	
	be filed within 72 hours after death with the Maryland ital Hygiene. ad other than "natural", or Items 23a or 28a-f show event, I'm McAlcal Examinat must be indiffed at event, I'm McAlcal Examinat must be indiffed at	Funeral	1 News Married 2 Married 1 No.	Decedent of Hispanic Origin? (Specify s, specify Cuban, Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Americ Black, White,	
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	iled within Hygiene. her than "		12 THGRADE DIS	18. Mother's Name (Fi	rst, Middle, Maider	N/A	1 - CINKNOWN)
Maryland	thould be find Mental Harked of marked of	To Be		SR. EARSY			
Mary	ls ar		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	Address (Street and Number or Rural Ro	Dute Number, City	or Town, State, Zip	Code)
	s 1 and 3 f Health Item 27 other tr		DAR LENE SELLMAN DALIGHTER 4 20a. Method of Disposition 20a. Method of Disposition 20b. Place of Disposition cemetery, cremate	on (Name of Date or of other place)		ocation - City or To	own, State
Baltimore,	permit. Pages Department of I Important: If Ite any injury or or		1 Burial 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify) GARRISO.	N FOREST 11-05	-04 OW	INGS MI	LLS, MD,
Ba	permit. Departr Importa any inji	6 10	21. Signature of Funeral Service Licensee	N FOREST 11-05 ame and Address of Facility BROW 45 N FULTON A	VE, BAL	TO, MD	21217
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter t shock, or heart failure. List only one cause on each line.	he mode of dying, such as cardiac or re	spiratóry arrest,		Approximate Interval Between Onset and Death
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	Examiner	L	Sequentially list conditions.	evosis			
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8760,	cate be executed physician and s the burial-transit						
9	tificate ng phys as the	Aedical					
Вох	The law requires that the death certifi site has been signed by the attending bage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ec	topic pregnancy ther (specify)		23d. Date of deliv Month	ery Day Year
P.O.	that the de led by the a detached	hysic	1 Yes 2 No 9 Unknown		Did tabassa	uan anatributa ta t	he cause of death?
	uires that signed b	by	De voi vation Preumonia	rrying cause given in Part I.	./		pably 4 Unknown
Records,	ie law requir has been si je 2 should	Completed			24a. Was an autopsy	prior to co	opsy findings available impletion of cause of
al R	n: The licate har r, page			26. Place of Death C	performed? 1 Yes 2 N	death? o 1 ☐ Yes	2 No
f Vital	Physician: r this certific ral director,	To Be	examiner?	3□ DOA Other: 4 Wursing Home	5 Residence		fy)
on of	ding Pt h. After th funeral			28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	I. Describe how inji	ury occurred	
Division	r Attending er death. rector: Aftel by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (Specify)	t, factory, office 28f	Location (Street a City or Town, Stat	and Number or Rur te)	al Route Number,
	spital o	ai Cer	29a. Certifier 1 Vertifying Physician: To the best of my knowledge, death o	ccurred at the time, date and place, and	I due to the cause(s) and manner as	stated.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investored and manner stated.	stigation, in my opinion, death occurred	at the time, date ar	ate signed (Month	o the cause(s)
	With To	2	29b. Signature and title of certifier	29c. License number 0003254	8 00	abera	28,2004
	77)		30. Name and address of person who completed cause of death (Item 23a) (Type, Pri	DOO3254 ONOTH Gree	ne Str	eet R	altimore
		ate	ACT I - /IDID	101.20.	01.	• • •	
B	Regist	rar	LOUT JOHNSON	Ana V			

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2004 34551 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 30, 2004 **Physician** 7:10 pM Alta Stinchcomb /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Oak Crest If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 25, 1916 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign 6 Sex **Funeral** Months 1□ M 2 KF 88 217-01-6374 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 27 is marked other than "natural", or Iteme 23a or 28a-f ehow traumatic event, the Medical Exart is or mast to notified at 1 Tyes 2 XNo Baltimore Md. Baltimore Directo 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA #1520 8810 Walther Blvd. Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 🔀 No 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) +3 Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) land 17. Father's Name (First, Middle, Last) Be Bertha L. Aehle John F. McDonald Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 is m any injury or othar traum once. 1040 Deer Ridge Dr. Unit 304 Baltimore , Md. 21210 Corinne A. Jones/ Daughter 8 30100 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Co. 11-1-04 Towson, Md. `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
RUCK TOWSON Funeral Ho 21. Signature of Funeral/Service Licensee Home: Incoa Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part1, Enter the disease. shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cerebral Vasco las disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 🗌 Yes Hospitel or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death. Diractor: Af 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0586 46 November 1 monios 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) monias Boulevard MO walther 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 1 - 2004

DHMH 17 Rev 1/2001

TINCHUMB

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34552 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) TAM Month **Physician** Shelton 10 OU Helen /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Baltimore Hice Manor 2095 Rock Rosa Ave If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Hours 1□ M 2/√XF Months Days 85 Director 08/18/1919 VA 220-01-4199 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10e. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nature!, or items 23a or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at educe. 1 TyYes 2 □ No BALTIMORE MD N/AFuneral Director 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 21201 1100 PENNSYLVANIA AVENUE 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Yeer or Dates: Specify: BLACK 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) BUS ATTENDANT SCHOOL SYSTEM 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) ROBERT SHELTON ALEASE EDMONDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 905 PAYSON ST., BALTO., MD 21217 FREDERIC SHELTON/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 △ Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State Date 10/29/04 BALTO., MD 4 ☐ Donation 5 ☐ Other (Specify) KING MEM. PARK 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signatur of Funeral Service License 1701 LAURENS ST. BALTO., MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Extensine cerebrolascular accident Examine Examiner Ceronan disease 1. 3 Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury or Attending Physician: The law requires that the death certificate be axec Division of Vital Records, P.O. Box 68760, 17 pertension Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): perlipidemia 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Seithre discreter 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Degenerative toint disease 1 Yes 2 No 1 ☐ Yes 2 🖎 No coral pherynjeal dysphagia 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2No 9 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 Yes 2 No death. To the Hospital or Attendit within 24 hours aftar death.
To the Funerel Director: All completely filled in by the fu 2 ☐ Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 030115 10/28/4 30. Name end address of person who completed cause of death (Item 23a) (Type, Print) HIOK Pehai, mo 2600 LISERY HEITS AVE BOH, ms 21215 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

2004

State of Maryland / Department of Health and Mental Hygien 004 34553 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 8:15A. 1. Decedent's Name (First, Middle, Last) 2. Date of Death oct. **Physician** 23, Madeline Elizabeth Stokes /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchey Hospice n/a Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. June 2, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 219-40-9008 1 M 20F 1942 62 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State item 27 is marked other than "netural", or items 23s or 28s-4 show other traumatic event, the Medical Examinar must be inclined at 1 ☐ Yes 2 No Maryland Baltimore Cockeysville Director the 10g. Citizen of What Country? 10e. Street and Number Apt.T3 USA 304 Lord Byron Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 Yes 2√2 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within in and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 9th grade Child Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James P. Gray Florence Roberta Pinkney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau 3106 Harford Road Baltimore, Maryland 21218 Michael D. Stokes/ Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place) 10/30/04 Dulaney Valley Memorial Gar. 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Timonium, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Licensee 22. Name and Address of Facility Chatman-Harris Funeal Home 5240 Reisterstown Rd Baltimore, Md 21215 Kray Hour 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Open and Death Immediate Cause (Final disease or condition resulting in death) Immundekereny Virus Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Clus to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 poinths? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🙀 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Magner of Death 28d. Describe how injury occurred 28b. Time of Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Dafe signed (Month, Day, Year) 29b. Signature and title of certifier 10 of death (Item 23a) (Type, Print) Charles St Parkmore, NO 21212 32. Registrar's Signature State NOV 1 Registrar

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Madeline

1. December Name (First, Motion, Last) Trimothy Fart Smith Trimothy Fart Trimothy	932		State of Maryl	land / Depa <i>Ce</i>	artment of H	lealth and M Death		er 2 0 0 4	34554
A polity Name Provided Prov									3. Time of Death
Feminal Arms Arms Arms Arms Arms Arms Arms Arms			Timothy Farl Smith				October	25, 2004	7:36 P M
Anne Arundel Medical Center 10		_			4b. City, Town, or	Location of Death		4c. County of Deat	h
Second Security Number Second S	Examine	61	Anne Arundel Medical Center		Annapo	olis		Anne A	rundel
Part	Euroval			yrs. last birthday)			8. Date of Birth	9. Birt	hplace (State or Foreign
Use Bestimone of Decedent 10s. Carry Town or Location Waryland Arme Arundel West River 10s. State 10s. County 10s. County 10s. State 10s. County 10s. County 10s. County 10s. County 10s. County 10s. Count			219-06-4538 ^{1ăm 2□F} 35	5 Yrs.	Months Days	Hours Min.	10-7-19	69 Mar	yland
Maryland Anne Arundel West River 100. Sizes and Mumber 100. Sizes 100. Siz			Usual Residence of Decedent						
The second form of the second secon	yłanc 10W		10a. State 10b. County 10c	c. City, Town or Le	ocation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
The second form of the second secon	Mar Mar	to	Maryland Anne Arundel	West R	iver				T Tes Z Z No
The second form of the second secon	r 28e	irec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	ountry?
The second form of the second secon	3a o	Ē	5146 Cedarlea Drive		20	778		USA	
The second form of the second secon	ms 2	Jer		in U.S. 13.	Was Decedent of H	lispanic Origin? (Span. Mexican, Puerto	ecify Yes or No- Rican, etc.)		
17. Father's Name (First, Middle, Maidlen Sumane) 18. Mother's Nam	or Ite		1 Never Married 2X Married 1 ☐ Yes 2 X No				, , , , , ,		
17. Father's Name (First, Middle, Maidlen Sumane) 18. Mother's Nam	al, c	by	3 Widowed 4 Divorced Year or Dates:		12 100 223 110				
17. Father's Name (First, Middle, Maidlen Sumane) 18. Mother's Nam	72 hc	tec	15. Decedent's Education (Specify only highest grade completed)	(Give	e kind of work done	during most of work.		16b. Kind of Business	/Industry
17. Father's Name (First, Middle, Maidlen Sumane) 18. Mother's Nam	thin and	npie	Elementary/Secondary (0-12) College (1-4or 5+)					D.C. Haard	tal Contor
Part David Smith Teslie Rebecca White Farl David Smith Teslie Rebecca White Farl David Smith Teslie Rebecca White Farl David Smith Teslie Rebecca White Teslie Rebe	od wi	Co		Faci.	lity Engi				tar Center
Danielle E. Smith/ Wife Danielle E. Smith/ Wife Danielle E. Smith	al Hy al Hy soth		, , , , , , , , , , , , , , , , , , , ,						
Danielle E. Smith/ Wife Danielle E. Smith/ Wife Danielle E. Smith	Ment Ment	ို							
20. Location - City or T 20. Method of Disposition 20. Disposition (Amen of considering), certainty of orther place) 10-30-04 Edgewater, 20. Location - City or T 20. Method of Disposition 1 Burial & Microral Solution 20. Disposition 20. Dispo	2 sho and is m		19a. Informant's Name/Relationship (Type, Print)						ZIP Code)
Surgiciary 10-30-04 Edgewater, 10-30-04 Edge	and salth n 27		Danielle E. Smith/ Wife				t River,	MD 20778	Town Chat
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. New York Part Par	of He of He roth		20a. Method of Disposition 2 Micromation 3 Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. New York Part Par	Pag nent ant: I								
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Shock, or heart failure. List only one cause on each line. New York Part Par	rmit. partr ports y inje		21. Signature of Funeral Service Licensee				_		
Spoose of the state of the stat	50 E E 9		14hull illel-						MD 21037 Approximate
The part of the past 12 months? So the past 12 months 12 mo	/Medical Examiner	Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C.	onsequence of):					Interval Between Onset and Death
9 Unknown 1	ertificate be ling physici e as the bu		d	pregnancy				23d Date of de	livery
To be defined as the state of the significant conditions of the si	he death c the attenc	ysician	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	Fetal death 3		ey .			Day Year
24a. Was an autopsy performed? 1	that I		Part II. Other significant conditions contributing to death but n	not resulting in the	underlying cause gr	ven in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
The state of the s	sign d be						1 □ Ye	as 2. XNo 3□P	robably 4 Unknown
25. Was case referred to medical examiner? 1 XYes 2 No 26. Place of Death (Check only one) 27. Manner of Death 28. Describe how injury occurred 28. Place of Death (Check only one) 28. Injury at Work? M 1 Yes 2 No 28. Injury at Work? M 1 Yes 2 No 28. Describe how injury occurred	he law e has t age 2 s	complete					autops perform	y prior to ned? death?	utopsy findings available completion of cause of
The state of the s	lan: rtifica ctor,	O	25. Was case referred to medical				th (Check only on	(8)	
So to		0	Hospital:	2 X ER/Outpati	ent 3 DOA	her: 4 Nursing H			ecify)
The state of the s	_ = 0				of 28c. Inju	iry at ork?	28d. Describe ho	ow injury occurred	
3 Suicide 4 Homicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only office) 29a. Certifier (Check only office) 29a. Certifier (Check only office) 29b. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only office) 2	ne at se	atic	2 Accident investigation						
The state of the s	or Attorifier de lirector n by th	rtific	determined 286. Flace of Injury	- At home, farm, s 'Specify)	street, factory, office		28f. Location (St. City or Town	reet and Number or Fi n, State)	urai Houte Number,
	Hospital 24 hours a Funerel C		(Check only 2 Medical Examiner: On the basis of ex	xamination and/or	ath occurred at the t investigation, in my	ime, date and place, opinion, death occur	, and due to the carred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
29c. License number 29d. Date signed (Month)	thin 2 tha tha	Mec			29c. Licen	se number	2	9d. Date signed (Mon	th, Dey, Year)
O.C.M.E. October 26,	F * 5 8	-	· HOWWIN			.C.M.E.		October 26	, 2004
30. Name and address of person who com cause of death (Item 23a) (Type, Print) 5. C. HOGAW 111 Penn Street, Baltimore, Maryland	13		30. Name and address of person who com cause of deat	th (item 23a) (Typ	e, Print) 111 Penn	Street, B	altimore	, Maryland	21201

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signa

NOV 1 - 2004

32. Registrar's Signature

& Sports

Completely filled in	Madica	29b. Signature and title of certifier	and manner stated.		29c. License numb	ber	29d. Date	signed (Month, Day, Year) 31 200 4
i pell		29a. Certifier 1 ☐ Certifying P (Check only 2 ☐ Medicel Exe	hysicien: To the best of my kr miner: On the basis of examin	nowledge, death occu nation and/or investig	urred at the time, dat pation, in my opinion,	te and place, and due t death occurred at the	time, date and	and manner as stated. place, and due to the cause(s)
a in by the t	Certification	3 Suicide 6 Could not determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, street, fa	actory, office	28f. Loca City	or Town, State)	l Number or Rural Route Numb
tuneral director, p		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Des	Hesidence 6	
lirector		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	TER/Outpatient 30	0.1	Place of Death (Check Nursing Home 5		Other (Specific)
age 2						10	Was an autopsy performed? Yes 2 No	24b. Were autopsy findings av prior to completion of cau death? 1 ☐ Yes 2 ☐ No
9 3	בּ	Part II. Other significant conditions Out them i c		isulting in the underly	ing cause given in P	Part I. 23e.		se contribute to the cause of de
detached for use as to	riiyaiciaiirime	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fel 4 Pregnant at time of 9 Unknown	tal déath 3 ☐ Ecto death 5 ☐ Othe	ppic pregnancy er (specify)			3d. Date of delivery Month Day Ye
and en	Cal CX	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	iquence of):				
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any injury or o	-	1 ☑ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specal Service Lice)	ify) N	Mt. Zion C		11-1-04		sdowne, Md. ore, Md. 21202
other	-2	Ruby Stewart		144 Ma Place of Disposition cemetery, crematory	Name of	, Wendell,		Carolina 2759 cation - City or Town, State
other treumatic		19a. Informant's Name/Relationship	• • • •					Town, State, Zip Code)
e event.	ם ו	7. Father's Name (First, Middle, Las Richard		ewart		Mother's Name (First, A	Middle, Maiden	Sumame) Perry
T. The Madical B	dio	Elementary/Secondary (0-12) 4th grade	College (1-4or 5+)	life. DO N	IOT use retired)	d Trackman	B.&	O. Railroad
oted b	naia -	15. Decedent's E	Education	(Give kind	Usual Occupation of work done during	most of working	16b. Kir	nd of Business/Industry
event, the Musical Exacultational Description of Processing Processing Processing Precedents	Dy runeral	Marital Status Never Married 2 Married Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	If Yes	s, specify Cuban, Me	ic Origin? (Specify Yes xican, Puerto Rican, el ecify:		14. Race - American Indian, Black, White, etc. Specify: Black
ust be	<u> </u>	2402 Edmondson	· · · · · · · · · · · · · · · · · · ·		21223			USA
Director	200	Md. Oe. Street and Number	NA	Baltim	Of. Zip Code		10g Citi	tk Yes zen of What Country?
4	-	Jsual Residence of Decedent 10a. State 10b. County		City, Town or Location				10d. Inside City
eral ctor		5. Social Security Number 6. 241–24–2886	Sex. 7. Age (In yrs			urs Min. 8. Date (Mon	of Birth oth, Day, Year) 2–12–18	9. Birthplace (State or Country)
amine		FUTURE CARE	1RVINIGTON	B	Altimore	MD		NA
	I -	a. Facility Name (If not institution, gi	EWART		City, Town, or Loca	tion of Death	28	Year 04 1030 County of Death
/siciar ledica	_	. Decedent's Name (First, Middle, L.	4517				of Death	3. Time of I

DHMH 17 Rev 1/2001

Box 68760 P.O. I Division of Vital Records, Hospitel or Attending Physicien: 24 hours after death. e Funerel Director: A To the within 24

Baltimore, Maryland 21215-0036

Carolice St. et 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME October 28, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7 MU-10 Alt All 111 Penn Street, Baltimore, Maryland 21201 CM314CCAH 32. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 1 - 2004 **ORIGINAL**

State Registrar

DHMH 17 Rev 1/2001

Medical

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				First, Middle,									2. Date of Month	Death	Day	Year	3. Time of Death
	Physician /Medical		Geral	dine R	edden	Shaw							OCTOB		28, 2	004	11:00A. M
	Examiner	4a. Facilit	ty Name (If n	ot institution,	give street	and numbe	er)				Location	of Death		l	4c. County		
0				thur E			A //	for and the leading office.	1000		JOHN If Under	24 Hrs.	8. Date of	Rirth	10NTGO	_	lace (State or Foreign
20	Funeral		Security Nur		6. Sex 1 ☐ M		Age (In yrs. i	ast <i>birtno</i> a) Yrs.	Months	Days	Hours	Min.	(Month,	Day, Ye	9ar)	Mary	try)
2	Director		-24-80 esidence of D				0.5					1	Aug.	,,	1721	rary	Land
	yland	10a. Stat	e	10b. County			10c. City	y, Town or I	ocation							1	0d. Inside City Limits
	Mar Be-1 st	Mary	land	Montg	omery		Cab	in Jo	hn					-			1 ☐ Yes 2 No
	with the Mai or 28e-1 s be notified	10e. Stre	et and Numb	per					10f. Zip						. Citizen of V		
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21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23s or 28s-1 show he Modical Exerciter must be notified at homeleted by Funeral Director		1	5. Decedent	's Education	n ,		16a. Dec	edent's Usua e kind of wo	l Occupa	ation	at af ward	rin a	16	b. Kind of Bu		
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pu	tal Hy d oth d oth	17. Fathe		irst, Middle, I											iden Sumam	16)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23a or 28e-f show any injury or other traumatic event, the Medical Exercities must be notified at any injury or other traumatic event, the Medical Exercities and pages. To Re Completed by Funeral Director	Per	-	ene Re		7:4		40h Ma	Un . A delena	/Ctt			Knoe		City or Town,	State 7in	Codel
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		71 31 Day		h, Day, Year,		32 Re	gistrar's Sign	ature	111 1	enn	Stre	æt,	Baltin	nore	, Mary	zland	21201
	Stat Registra	٠ ١	HOLI 4	- 2004		1º mar	- /	4	books								

State of Maryland / Department of Health and Mental Hygien 2004 34558 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 **Physician** Gilbert S. Singleton 4:00 A M October 28, /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Harborside Healthcare Center Baltimore 6. Sex 1 ★ M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-08-1944 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours South Carolina 212-42-4910 60 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 □ No Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 508 N. Stricker Street 21223 Items 23e Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other then "natural", or ite ury or other traumatic event, It a Medical Examination 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction Builder 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wila Mae Singleton Alex Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 N. Stricker St. Baltimore, MD 21223 Arlene Benbow/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State King Memorial Park Randallstown, MD permit. Page Department 11-02-04 Important: I any injury o once. 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 636 N. Cilmor St. Balto, MD 21217 hions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition e Physician resulting in death) /Medical **Examiner** neumo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (or as a consequence of): Examine The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) 4 Pregnant at time of death 9 Unknown s been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed this certificate 1 Yes Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Deat 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. investigation the f 6 Could not be determined 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical сопревену (Check onh 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier who completed cause of death (Item 23a) Type, Print) hd Bultimore no 21239 och Kaven 0 31. Date fifed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

State of Maryland / Department of Health and Mental Hygienes on

			Certificate of Death	Reg. No.	4 34559
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death Month Day Yes	3. Time of Death
	/Medi	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or U	Uctober 28,20	104 7:50 PM
	Examir	ıer		N/1	eath .A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth Worth, Day, Year)	Birthplace (State or Foreign Country)
	Director		212-32-5937 1 M 2 X F 68 Yrs. Months Days Hours Min.	May 8,1936	Virginia
	land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Mary 1-f ah	ţō	Maryland NIA Baltimore		1 XYes 2 □ No
	or 28	Funeral Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What	Country?
	ath wi	rai	6000 Belona Ave. 21206	US	SA
_	ter de Items	une	11. Marital Status 12. Was Decedent Ever in U,S. Armad Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	pecify Yes or No- to Rican, etc.) 14. Race - Ar Black, W	merican Indian, /hite, etc.
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	filed v Hygie other t		17. Father's Name (First, Middle, Last) 18. Mother's Nam	e (First, Middle, Maiden Surname)	n racking Co
/an	Ald be fental ked c	To Be	James Tolliver Fliz	a Hill	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Department of Health end Mental Hyglene. Important: If Item 27 is marked other than "netural", or items 23a or 28a-f ahow any Injury or other traumatic event, If a Medical Examiner must be indiffed at once.		19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Mailing Address (Street and Number or Ru	ral Route Number, City or Town, State	e, Zip Code)
	and lealth m 27 her tr		Ms. Chevon Hayes 301 W. 27 "St. 1	Salto, NId. 2	1211
Baltimore,	Pages 1 nent of H nnt: If Ite iry or ot		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City	or Town, State
語	nit. Pe artmer ortant Injury		4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service, Licensee 22. Name and Address of Facility	15/2004 Arbut	us, Ma.
Ba	permit. Departn Imports any inju		Joseph L. Russ	Funeral Home	
			23a. Parr Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	ve. balto, Ma, or respiratory errest,	2/2/6 Approximate
	Physician		show, or heart fature. List only one cause on each line.		Interval Between Onset and Death
9	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Metaylobic Breach (example)	aurev	
		e	Due to (or as a consequence of):		
	uted	Examiner	Sequentially list conditions. b. Due to (or as a consequence of).		
60	eath certificate be executed ettending physician and I for use as the burial-transit	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of):		
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P.O.	by the	hys	A 0	23b. Did tobacco use contribu	Probably 4 Unknown
ś	es the igned be de	δ	CUA, HTW, ASib, Avenuo.		
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Rec	has t	mp			completion of cause of death?
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Division of Vital Records,	ysicia Is cert direct	To Be	examiner?	th (Check only one) ome 5 ☐ Residence 6 ☐ Other (Sp	pecify)
n o	ng Ph fter th neral		27. Manner of Death 1 ☑Natural 5 ☐ Panding 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Universe Work?	28d. Describe how injury occurred	,
Sio	tendi death. tor; A the fu	cati	2 Accident investigation M 1 Yes 2 No	006 1	S/S
Div	ofter a plus of the contract o	Certification:	4 Homicide 4 Homicide 4 Sea. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or I City or Town, State)	nurai noute ivumber,
	ospita hours ineral y filled		29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause(s) end manner	as stated.
	To the Hospital or Attending Physician: The law requires that the death or within 24 hours efter death. To the Funeral Director: After this certificete has been signed by the ettend completely filled in by the funeral director, page 2 should be deteched for us	Medicai	(Check only opinion, death occurrence) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.		
	5 1 × 5 0	2	29b. Signature and title of certifier 29c. License number	29d. Date signed (Mor	
	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	39 10.2	4-05
	U		Vijay R. Heade, while 821 N. Eulow St., S	suite 308 Ballin	1012 M/ 2120

DHMH 16 Rev 6/95

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34560 1 - State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 29 **Physician** 9:04 nomas 04 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Merc If Under 24 Hrs. If Under 1 Year 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Days Min. 218-62-996 Usual Residence of Decedent Months Hours intry) 1 M 2 □ F Yrs. Director the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other then "naturel", or items 23s or 28e-f show other traumatic event, the Medical Examinar must be notified at 1 yes 2 □ No Directo Nary and 10e. Street and Number more 10g. Citizen of What Country? 10f. Zip Code 50 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pore 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ohnso ပ iam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and, Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 Is n eny injury or other traun once. 236 oma 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Removal from State 2004 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatore of Funeral Service Licensee 22. Name and Address of Facility uneral Home. Balto. Md. Home WNorth Jo 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shotly or heart failure. List only one cause on each line.

Immediate Cause (Final disease are conditions) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** rived /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4□Pregnant at time of death P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 1 🗌 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy performed? 1 ☐ Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSAC Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No Certification: To 1 🗌 Yes 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident after death filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funerel D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature apolitile of certifier 29c. License number 4085

State Registrar

31. Date filed (Month, Day, Year) NOV 0 1 2004 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOMAS, MARVIA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item & 100 to 100

			For State Registrar	Auciri 1	State of Maryla		ertificate d			en2004	34561
	Physicia	an	1. Decedent's Name (2. Date of Death Month	Day Yeer	3. Time of Death 8:58 AM
	/Medic Examin	al	4a. Facility Name (If no		THORPE treet and number)		4b. City, Tow	n, or Location of Deat	h CE 103E2	4c. County of Dea	
			9630 - 5. Social Security Num		7. Age (In vi	rs. last birthda		AT If Under 24 Hrs	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		215-30-	4434 10	M 200 F	Yrs.	Months Da	ys Hours Min.			TIMBLE, MO
	/land		Usuel Residence of D 10a. State 1	ecedent 0b. County	10c.	City, Town or	Location				10d. Inside City Limits
	ne Man 8a-f sh zilijed	Director	MD		IORE IS	SALT	IMORE				1 ☐ Yes 2 ₹ No
	with the		10e. Street and Numb	ENTH	ALE		10f. Zip Coo		10	Og. Citizen of What C	ountry?
	r death	Funeral	11. Marital Status	1	12. Was Decedent Ever in Armed Forces?	U.S. 1		of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
920	72 hours after death with the Maryland natural; or Itams 238 or 288-f show drail Examined - ust be notified at	by	1 ☐ Never Married 3 ☐ Widowed 4		1 ☐ Yes 2 No If Yes, Give Year or Dates:	THE CASE OF SHARE	1□ Yes 2	No Specify:		Specify:	HITE
21215-0036	"natur	Completed	1 (Specify	5. Decedent's Educ only highest grade	cation completed)	(G)	cedent's Usual Oc ve kind of work do b. DO NOT use re	one during most of wo	orking 1	6b. Kind of Business	/Industry
212	filed within Hygiene. other then "	Somp	Elementary/Second	ary (0-12)	College (1-4or 5+)	RE:	EARCH	CLER	K	AUTOM	OTIVE
and	ed tal	Be	17. Father's Name (Fi		RAYNO	7			me (First, Middle, M GARET	Maiden Sumame)	∨
Maryland	2 should and Men is marke aumatic	J	19a. informant's Nam	-			ailing Address (Str	eet and Number or R	ural Route Number,	City or Town, State,	Zip Code)
	ss 1 and 2 of Health itam 27		ERNEST 20a. Method of Dispos	THORIT	E HUSBAN	D. Place of Dis	sposition (Name o	IENITI	Date 2	ACTIMORE 20c. Location - City of	,
Baltimore,	0 0 = =		1 Burial 2 ☐ `4 ☐ Donation 5	Cremation 3 □R □ Other (Specify)	emoval from State		rematory or other		2004	PRKVILL	E, MD
Balt	permit. Pag Department Important: I any injury c		21. Signature of Fune	ral Service License	0/1	20	22. Name and Ad BROD LIA	ddress of Facility	~ 7 -	FEL OF MORE IM	MEMBRIES D 21254
			23a. Part1. Enter the shock, or heart	disease, or compli- ailure. List only on	cations that caused the de	eath. Do not		4-4-1			Approximate Interval Between
	Physician /Medical		Immediate Cause (Fi disease or condition resulting in death)	nal a	ATHEROSE	LEROTT	e COM	DNARY A	ATERY.	DISTASE	Onset and Death 5 Y 6 A S
	Examiner		Sequentially list cond	itions	Due to (or as a cons	sequence or):		DISTAS			3 YEARS
11/	red nsit	Examiner	if any, leading to imm cause. Enter Underly Cause (Disease or in	ediate ring	Due to (or as a cons				-		
0,0	ificate be executed g physician and as the burial-transit		that initiated events resulting in death) La	st	Due to (or as a cons	sequence of):					
68760,		edical			1						
Box	eath certif attending for use a		IF FEMALE: 23b. Was decedent p in the past 12 m	regnant	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F	etal death	3 □Ectopic pregna			23d. Date of de	elivery Day Year
o.	that the deg ed by the a detached fo	Physiclan/M	1 ☐ Yes 2 ☐ 9 ☐ Unknown		4□Pregnant at time o	of death	5 □ Other (specif)	/)			
S, P.	gr	by	Part II. Other signific	ant conditions cor	ntributing to death but not	resulting in the	e underlying cause	given in Part I.	23e. Did tob	4	o the cause of death?
Records,	w requir been si should	leted				-			24a. Was ar	42	utopsy findings available completion of cause of
l Re		Completed							autopsy perform 1 Pes 2	ied? death?	completion of cause of s 2 No
of Vital	Physician: this certific ral director,	Be	25. Was case referre examiner?		fospital: 1 ☐ Inpatient 2	P □ ER/Outpa	tient 3 DOA	04	ath (Check only one	nce 6 Other (Spe	ocify)
n of	ding Phys	on; To	27. Manner of Death	5 Pending	28a. Date of Injury (Month, Day Year	28b. Time	e of 28c.	njury at Work?	28d. Describe ho		жиу)
Division	l or Attandil after death. Diractor: A in by the fu	Certification;	2 ☐ Accident 3 ☐ Suicide	investigation 6 Could not be determined	28e. Place of Injury - A	at home, farm,		1 ☐ Yes 2 No	28f. Location (Str	eet and Number or R	lural Route Number,
Div	ital or A irs after ral Dirac led in by		4 Homicide	determined	building, etc. (Spe	ecify)			City or Town,	, State)	<u> 12</u>
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phys	sician: To the best of my ner: On the basis of exam and manner stated.	knowledge, de ination and/o	eath occurred at the investigation, in r	e time, date and plac ny opinion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and ti	tle of certifier	<i>B</i>	7 1		cense number		d. Date signed (Mon	
	,,,		30. Name and address	is of person who co	ompleted cause of death (Item 23a) (Tvi	De, Print)	30 55 7	06	10, 21,	2004 0 21239
_	j)	ELIAS C	FHANDS	our Good	SA/TA	RITAN	HUSSITAL	BALTI	nove, 17	0 21239
	St: Reaist	ate rar	31. Date filed (Month	Day, Year)	32. Registrar's Si	gnature	4 /	4			

		-	for State Registrar	State of Maryland		nt of Health and te of Death		ene 2004	34562
	Physici	an	1. Decedent's Name (First, Middle, Las	V Tumine	1/1		2. Date of Death Month	Day Year 27, 2004	3. Time of Death 3:30Am
	/Medic Examin	er	4a. Facility Name (If not institution, give	rook foad		Town, or Location of Deat Phoenix or 1 Year If Under 24 Hrs		8 a/fmo	re Co.
	Funeral Director		5. Social Security Number 6. Sec. 214-14-2906 10 Usual Residence of Decedent	T. Age (In yrs. las	Yrs. Months			(ear) 917 Ball	Amore, MD.
	Maryland -f ahow	tor	10a. State 10b. County Maryland Baltin	Λ Λ	Town or Location			10	od. Inside City Limits 1 ☐ Yes 2 No
	h with the 23a or 284 at be not	Funeral Director	10e. Street and Number 14027 Sunnybi	rook Road	10f. Z	2/13/	100	Citizen of What Count	A.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow important: If item 27 is marked other than "natural be notified at an angle of the page.	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	. 13. Was Deci If Yes, sp 1 ☐ Yes	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer 2. No Specify:	Specify Yes or No- to Rican, etc.)	14. Race - America Black, White, e	
21215-0036	within 72 ho ene. then "netur he Medical.)	Completed	15. Decedent's Ed (Specify only highest graded) Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life. DO NOT	ork done during most of wo	rking 16	Own H	ome
and	should be filed ind Mental Hygis marked other umatic avent, I	To Be Co	17. Father's Name (First, Middle, Last). Joseph	antazzaro			me (First, Middle, Ma	Ranzino	>
, Maryl	and 2 sho salth and I n 27 Is ma		19a. Informant's Name/Relationship (7 Mr. Joseph M.	Tuminelli	4 Mck	AHUR Co	ural Route Number. Co	City or Town, State, Zip (CKEYSVI) (P)	MD, 21030
Baltimore	Pages 1 an nent of Heal int: If item 2 iry or other		20a. Method of Disposition Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	ce of Disposition (Nametery, crematory or	Mem. Gar. O	t. 29, 2004	oc. Location - City or Tov	
Balti	permit. Pag Department Important: I any inlury o		21. Signature of Euneral Service Licen	- gan, s.	PEAC 23	and Address of English	natives d. Timo.	Funeral+C	remation Ctr. 21093
	Physician /Medical Examiner	ner	23a. Part. Enter the disease, or come shock, or heart failure. List only a limediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a. Due to (or as a conseque	piralio Hs wi	nde of dying, such as cardia on Inles	c or respiratory arres		Approximate Interval Between Onset and Death Sand Death Monins
760, 4	ite be executed sysicien and ne burial-transit	cal Examiner	Cause (Disease or infury that initiated events resulting in death) Last	c. Due to (or as a conseque	ence of):)			gens
.O. Box 68	death certifica e attending ph ed for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dead 9 Unknown	death 3 Ectopic			23d. Date of deliver Month	ry Day Year
<u>α</u>	requires that the een signed by th nould be detache	by	Part II. Dther significant conditions o	ontributing to death but not result	ting in the underlying	cause given in Part I.		cco use contribute to the	
I Records,	The larate has	Completed					24a. Was an autopsy performs	prior to com death?	esy findings available apletion of cause of
Vital	ding Physicien: Th h. After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.11	ath (Check only one)		
of	Phys this ral dir	.T	1 Yes 2 No 27. Magner of Death	1 Inpatient 2 E	R/Outpatient 3 [A Nursing I	Home 5 Residen 28d. Describe how	ce 6 Other (Specify,	1
O	fe fe	tlon	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No			
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, facto	pry, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
	Hospit 4 hour Funere ely fille	ical	29a. Certifier 1 Contifying Ph (Check only 2 Medical Exam	ysician: To the best of my know	dedge, death occurre on and/or investigation	d at the time, date and placen, in my opinion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner as sta e and place, and due to	ited. the cause(s)
	ro the vithin 2 o the complet	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	290	d. Date signed (Month, E	Day, Year)
	- > F O		F. Delos	Com obo		032717		10/28/0	4
	١		30. Name and address of person who	completed vause of death (Item:	23a) (Type, Print)	7505 0 TOWSON	SLIM D	21204	
	St Regist	ate rar	31. Date filed (Montal Day Year) 2	32 Angistras Signatu	ure & Age	norther			

			1 - For State Registrar	State of Marylar		artment of I			ene g. N2 0 0 4	34563
	Physici	20	1. Decedent's Name (First, Middle, Last)		-			2. Date of Death		3. Time of Death
	Physici /Medic		Phyllis Rapa Tobi					October	27, 2004	9:40P M
	Examin	er	4a. Facility Name (If not institution, give st Suburban Hospital	•		4b. City, Town, o	or Location of Deat	h	4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		Montgome 9. Bir	thplace (State or Foreign ountry)
	Director		023-24-2032	M 2 X F 72	Yrs.	Months Days	Hours Min.	Apr. 14	1932 Mas	sachusetts
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mary I-f sho	to	Maryland Montgomer	ry Ro	ckvill	e				1 X Yes 2 □ No
	th the	irec	10e. Street and Number	, 110		10f. Zip Code		10	g. Citizen of What Co	ountry?
	ath wi	raic	11406 Hounds Way			20852			Inited Sta	tes
	ter de Items	Funeral Director	11. Marital Status 1. Never Married 2. Married 1. Married 2. Married 1. Marr	2. Was Decedent Ever in U Armed Forces?	.S. 13. \	Was Decedent of I f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Ame Black, Whi	
99	urs af	by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2█ No	Specify:		Specify: Wi	nite
21215-0036	72 ho	Completed	15. Decedent's Education (Specify only highest grade		16a. Deced	dent's Usual Occup	pation during most of wor	rkina 1	6b. Kind of Business	
121	within ne. then "	mpj	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retire Estate 1	d)	9	Real Esta	4. -
d 2	filed Hygie other	e Co	17. Father's Name (First, Middle, Last)		Kear	Estate I		ne (First, Middle, M		re
<u>lan</u>	Aental Aental rked tic ev	To Be	Ernest Rapa				Rose P	itochelli		
lary	2 short		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	g Address (Street	and Number or Ru	ıral Route Number,	City or Town, State, .	Zip Code)
e,	l and lealth om 27 sher tr		Francis Lyon Tobin 20a. Method of Disposition			South St	nadow Hil		ne Tree,	
Baltimore, Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importent: If item 27 is marked other then "netural", or items 23a or 28e-1 show any righty or other treumatic event, the Madicial Examinat must be notified at once.		1 Burial 2 □ Cremation 3 □ Re	mayal from State	emetery, cren	natory or other pla ille Unic	n HOVE	mber 4,	0c. Location - City or	
ij	nit. Partme partme corten injury		' 4 □ Donation 5 □ Other (Specify) 21. Signature Truheral Service Licensee		Cemet	tery Name and Addre	2004 Iss of Facility Ro	bert A. P	umphrev Fr	le, Maryland uneral Home/
ä	Dep Imp any		Lalend .	M00	803 B	ethesda-(ethesda,	Chevy Cha Maryland	se Inc. 20814-3	7557 Wisc 501	onsin Avenue
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	e cause on each line.	h. Do not ente	er the mode of dyir	ng, such as cardiad	or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ntra	cere	bral	Hen	orrhag	_	Onset and Death
	/Medical Examiner		Total and an addition	Due to (or as a conseq	uence of):	•		1		, ,
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):					
to	be executed sician and burial-transit	Examiner	that initiated events							
8760,	be execian a	ai Ex	resulting in death) Last	Due to (or as a conseq	uence of):					
687	ate Pe	edicai	d .							
Box (death certifica attending ph d for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna		le			23d. Date of del	ivery
	e deat he atte	sicia	in the past 12 months? 1 🗆 Yes 2 🖼 No	4☐Pregnant at time of d		Ectopic pregnancy Other (specify) _	/		Month	Day Year
P.O.	that the de ed by the a detached t		9 ☐ Unknown Part II. Other significant conditions conti	ributing to death but not res	ulting in the un	derhing cause giv	en in Part I	23e Did tobs	icco use contribute to	the cause of death?
Division of Vital Records,	se us eg	d by	3		anny in the di	idonying oddoo giv	on any care.			obably 4 Unknown
CO	aw requir ts been si 2 should	Completed						24a. Was an	24b. Were au	stopsy findings available
- Re		Com						autopsy performe 1 ☐ Yes 22	prior to death? SNo 1 ☐ Yes	itopsy findings available completion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					th (Check only one,		-3/10
of o	Physic this c	To:	1 ☐ Yes 2 No Ho 27. Manner of Death		ER/Outpatien		4 🔲 Nursing H		ce 6 □Other (Spec	cify)
OU	tending Physicien: Jeath. tor: After this certific the funeral director,	tion	1-Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ∐No	28d. Describe how	njury occurred	
Visi	or Attendation description of the description of th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru	ıral Route Number,
ō	ital or A								·	
	To the Hospital or Attending Physicien: within 42 4 hours fater death. To the Funerel Director. After this certifical completely filled in by the funeral director,	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	tion and/or inv	estigation, in my o	pinion, death occu	rred at the time, dat	e and place, and due	to the cause(s)
	To T To I	Σ	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month	n, Day, Year)
•	0,		100	- MP	. 00.1 ~	D 5	6652	0	tober 2	8,2009
	\		30. Name and address of person who com MGH) hew Poffe 31. Date filed (Month, Day, Year)	npleted cause of death (Item	23a) (Type, F	Medica	1 center	Dive	1. Date signed (Mont) 1. Fobr 2 Rock-1	14 MD
	Sta Registr			32. Aegistrar's Signa	B A	parks				-

TOBIN, PHYIIIS 10/27/64@ 94/pm

Amend item #20, per Printin Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene O. 1. For State Registrar 004 34564 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month October 29,2004 MABEL MAIN WILSON 12:27 a. ™ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heart Homes 1414/1420 Front Ave. Baltimore Lutherville If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Y Oct. 12, 9. Birthplace (State or Foreign Country) Baltimore 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 81 219-18-9800 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, the Medical Exact par must be roctified at 1 ☐ Yes 2 No Director Maryland | Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 403 Dumbarton Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itan any nijury or other traumatic event, the Medical Eracula Black, White, etc. ☐Yes 2☐No 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: þ If Yes, Give 22 Year or Dates: White 3 ♥ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) +5 Elementary/Secondary (0-12) Trust Officer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabel Koblentz Charles Wellington Main 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Dumbarton Road Baltimore, Maryland 21212 Edwin P. Wilson (son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Crematory 10/29/04 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Mitchell-Wiedefeld F.H. Inc. 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused that shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition COLONAS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner as the burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Year Day 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown ģ signed Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 Yes 2 No 3 Probably 4 Unknown Completed peen ? 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Absidence 6 Nother (Specify) Assisted Certification: To 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA SIL funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Living 1 Natural 5 Pending Injury 1 Yes 2 No 2 Accident investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

2004

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

with the Maryland

death

Baltimore, Maryland 21215-0036

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34565 For State Registra MEND FIRM #15 PER FH C837 1 Profit 64 temps Death Reg. No. 2. Date of Death 3. Time of Death cedent's Name (First, Middle, Last) Month Year **Physician** Williams October 2004 /Medical Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner Mar timore 7. Age (In yrs. last birthday)
Yrs. If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign
 Country) 5. Social Security Number **Funeral** Min. 1 M 2 F 214-20-6413 Director 100 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Exundral must be invitilled at 1XYes 2 ☐ No Funeral Director timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3 212 NA death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: Charlet 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5 laster legi SOI 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hitent: If item 27 is marked ott jury or other traumatic even Be ဂ္ Ohnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3039 WOOD Ring Baltimore, Date City or Town, State 20c. Location -Method of Disposition cemetery, crematory or other place) RBurial 2 ☐ Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 29/04 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee vices P.A. oad Approximate Interval Between Onset and Death 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Intrucranial hemorrhay **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underving Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 plonths? Month Day Year 4 Pregnant at time of death 5 Other (specify) Yes ed by the detached 9☐ Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? has 2 No certificate 1 ☐ Yes 2 No 1 Yes Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 Ø Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 2 this 28a. Date of Injury (Month, Day Year) Director: After the in by the funeral 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 □ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funere tactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2004 30, Name and address of person who compared cause of death (Item 23a) (Type, Print) Riseberg 21200 ST 32. Anaistrar's Signature 31. Date filed (Machine) 1 Year) 2004 State

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrer 34566 Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death CHARLES Month WHITE, JR. Day WALTER **Physician** Year 3:50P OCTOBER 29, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 804 LANNERTON ROAD BALTIMORE MIDDLE RIVER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, Year) APRIL 23, 1920 6. Sex 1 🛣 M 2 🗆 F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 84 TEXAS Yrs. 234-22-0561 Director Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral', or Itams 23a or 28a-f show Examiner is ust be notified at MD BALTIMORE MIDDLE RIVER 1 ☐ Yes 2 XNo Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 804 LANNERTON ROAD 21220 U.S.A. filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: WHITE er than "natural", 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CIVIL SERVICE POST OFFICE 10 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHARLES W. WHITE, SR. ANTIONETTA (Hansen) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PATRICIA MURPHY/ DAUGHTER 144 OSBORNE AVE BAY HEAD, NJ 08742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEMETERY 11-1-2004 MIDDLE RIVER, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licensee 1211 CHESACO AVENUE ROSEDALE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHEENIC Obstructive Pnysician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last rsician and e burial transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Completed by Physiclan/Medical the th IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atten for u 2 Fetal death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 4☐Pregnant at time of death o the 9 Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 XNo 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 5 esidence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours af To the Funeral D completely fillad in Exertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month. Day, Year) 29b. Signature and the of certifier 29c. License number \$35410 pleted ca se of death (Item 23a) (Type, Print) HO 2223 6918 BATIMORE, KIDGE PFEFFERMO LIYA 32. Regionar's Signature 31. Date filed (Month, Day, Year) State NOV 0 1 2004 Registrar

		1- State of Maryland / Dep Registrar Ce	artment of Health and I artficate of Death	Mental Hygi	re Legible. ene . 2004 3456
Physicia /Medica Examina	al	1. Decedent's Name (First, Middle, Last) RONALD A. WALTER 4a. Facility Name (If not institution, give street and number) 5244 Fawn Grove Road	4b. City, Town, or Location of Death Pylesville	2. Date of Death Month Oct.	Day Year 22, 2004 9:30 p ^N 4c. County of Death Harford
Funeral Director		5. Social Security Number 217-64-2697 G. Sex 1 ▼ M 2 □ F 49	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,) 10/11/1	9. Birthplace (State or Foreign
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21215-0036 Identity 72 hours after death with the Maryland giene. In than "natural", or fleme 23a or 28a-f ehow it the Mardical Examiner must be notified at	ted by Fune	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spiff Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
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Baltimore, permit. Pages 1 ar Department of Haa Important: if item any injury or other		1 ★ Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensea	or Cem. 10/	27/04 Fc	c. Location - City or Town, State Drest Hill, MD
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Divisi To the Hospital or Attenwithin 24 hours after dealt To the Funeral Director: completely filled in by the Medical Certifical	2:	9a. Certifier (Check ory one) 1 Certifying Physician: To the best of my knowledge, death of 2 Medical Examiner: On the basis of examination and/or inverse and manner stated. 9b. Signature and title of certifier	29c. License number	29d. D	and place, and due to the cause(s)
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	Physici	20	1. Decedent's Name (First, Middle, Last,)				2. Date of Death Month	Day Year	3. Time of	Death
4	/Medic		Stephen D. Ward					October	27, 2004	9:54	A M
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36	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "natural", or flems 23e or 28e-f show event, the Medical Examinar must be mailfied at	y Funerai	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2€ No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:		
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lan)	and and sm		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailir	ng Address (Street a	nd Number or Run	al Route Number, C	City or Town, State, 2	(ip Code	
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Baltimore,	ges fa		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ F		o. Place of Dispo cemetery, cres Riverv	natory or other place) Nove	mber 1 W	illiamsto	Town, State Wn ,	
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Вох	eath certific attending pl	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre-		Ectopic pregnancy			23d. Date of deli	,	
0.	at the dea by the at	/sici	1 Yes 2 No	4☐ Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Y	rear .
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)	./) Clarm	MI, Jayde	an Mil	0. 05	9929		10-27.	- 200 4	1
	15		30. Name and address of person who co				,				
	1		Aaron M. Snyder, M			nter Drive	e, Rockvi	lle, Mary	yland 2085	50	
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 - 2004	32. Registrar's Sig	gnature	Sparks					

			Amend item 8 per the 837, 11	epartment of He	ealth and Me	ental Hygie	neo a co	01560
			Tregion L	Certificate of D		rivy.	No. 2004	34569
	Physici		1. Decedent's Name (First, Middle, Last) ANNA TANCHOSKY			2. Date of Death Month	Day Year	3. Time of Death 8.35AM
ž	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or L	ocation of Death	10	4c. County of Death	0.00.
			HARBORSIDE HEALTH CARE		MORE			
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 1 9 - 7) 5 - 76 75 10 M 207 83	thday) If Under 1 Year Months Days Yrs.	Hours Min.	8. Date of Birth Month, Day, Ye		otace (State or Foreign htry)
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	hours after death with the Maryland tural; or Iteme 23a or 28a-f show at Eran, at must be notified at	ō	10a. State 10b. County 10c. City, Town MD Harford	Bel Air				10d. Inside City Limits XXYes 2 □ No
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	er des	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{\text{Never Married}} \) Never Married	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Spec , Mexican, Puerto R	ofy Yes or No- lican, etc.)	14. Race - Americ Btack, White,	
036	hours aft tural', or	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates:	1 ☐ Yes 2 📈 🗘 0	Specify:		Specify: whi	te
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מפ		BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name			
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Maryland	~ a = 9			. Mailing Address (Street an				
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<u>E</u>	Pages nent of ant: If it ury or o		1 Bunal X Cremation 3 Hemoval from State	s Eagle Cre		10/22/0	4 Leola,	PA
Baltimore,	permit. Pages 1 Department of H important: If ite any injury or ott		21. Signature of Funeral Service Licensee	22. Name and Address Harkins F.		600 Mai	nSt.,Del	ta,PA
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Division of Vital Records, P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as if	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetat death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of delive Month	ery Day Year
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isio	death ctor: /	licat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of trijury - At home, fa		es 2 No	8f. Location (Stree	t and Number or Rura	I Route Number
<u>S</u>	al or A s after of Direct	Certification:	4 Homicide determined building, etc. (Specify)	am, enou, radiory, omog		City or Town, S		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical (29a. Certifier (Check only one) 1 CertifyIng Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination an and manner stated.	e, death occurred at the time nd/or investigation, in my opi	e, date and place, a inion, death occurre	nd due to the caus d at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier Personal miles	29c. License	NY & Y		Date signed (Month,	
			30. Name and address of person who completed cause of death (Item 23a) SHOAID A. HASITML 821	(Type, Print) N. EUTA	in St &	inte 30	V, Balh	muse
~		ate	31. Date fited (Month, Day, Year) 32. Registrar's Signature				~~~~	11
DH	Regist	-	NOV 1 - 2004 Denve	& Spain	en -			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [] 34570 1 - For State Registrar Certificate of Death 2. Date of Death 2004 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 6:00 deoraia GUNG /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number City, Town, or Location of Death Examiner Wilson Healthcare

5. Social Security Number | 6. Sex Montgonery Onter 7. Age (In yrs. last birthday) If Under 24 Hrs Date of Birth (Month, Day, Year) e or Foreign **Funeral** 1□ M 200 F 98 Yrs. 215-10-9119 Director Usual Residence of Deced 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f show the Medical Exertener must be notified at 1 ☐ Yes 2 No Montgomera Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ò Items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 and Mental Hygiene. Is marked other than "natural", or 1 ☐ Yes 2 No Specify Specify: Dhite 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be file.
Deparment of Health and Mental Hyg.
Importent: If Item 271s marked.
eny injury or other to 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Robert ANIER IRGINIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's ame/Relationship (Type, Print) Ate 20c. Location - City or Town, State 3310 Thick Branch Kd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 Removal from State 10/28/04 BALTIMORE, MA tarkwood Cencyery 22. Name and Address of Facility BAUTI MORE, MD 21231. 21. Signature of Funeral Service Licenses CHAPEL, 8800 HARFORD RD EVANS FUNERAL Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications to at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line Pnoce Immediate Cause (Final disease or condition resulting in death) **Physician** money /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Examiner burial-transit Due to (or as a consequence of) physician the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year for 4☐ Pregnant at time of death 5 Other (specify) signed by the a P.O. 1 Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 1 No 3 Probably 4 Unknown certificate has been signector, page 2 should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 No 1 Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Mannet of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 Tyes 2 No investigation within 24 hours after death To the Funerel Director: / completely filled in by the f 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} 🛮 🔛 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ro the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 26,2004 004115 I Roberts ischba

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month)

Dacks

201RUSELL AVENUE GAITHERSBURG, MD 20879

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/RUSSELL CHBALH MA) 64(TIFERSRIA

32. Registrar's Signature

Beper

State of Maryland / Department of Health and Mental Hygiene 2004 34571 For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** October 31, 2004 4:00 A Filiberto Arroyo, Sr. /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab Center Crofton Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours **№** M 2 F Director 82 March 16,1922 Puerto Rico 582-40-8062 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depentment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, It's Medical Examinat must be restited at 1 XYes 2 No Director Hillsborough Florida Brandon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 848 Greenbelt Circle 33510 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Puerto Rican 1 X Yes 2 ☐ No þ Specify 3 ☐ Widowed 4 ★ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th Self-Employed Produce Merchant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vicente Dolores Perez 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 817 Brandon, Florida 33510 Filiberto Arroyo, Jr./son 20b. Pface of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) West Arundel Crematory 11/2/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. once Thomas uanita Odenton, Maryland 21113 1411 Annapolis Road M00957 23a. Pert 1 anter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician 2 weeks Pneumonia /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ ate has been sign page 2 should be Peripheral Vascular Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Cerebrovascular Accident autopsy performed? certificate 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 1 ☐ Yes 2 X No Certification: To W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this tuneral 28a. Date of Injury (Month, Day Yeer) 28b. Time of fnjury 27. Manner of Death injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s after death 2 Accident filled in by the 6 Could not be determined 3 🖺 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 2, 2004 D35848 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gambrills, Maryland 21054 <u>1438 Defense Highway</u> Howard K. Schultz

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 3 2004

32. Registrar's Signature

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			For	State of Maryl		•		Mental Hyglen	2004	34572
			1 - State Registrar			Certificate of	Death	Reg. N	F 004	
	Physicia	an	Decedent's Name (First, Middle, Last	st)	151	DALT		2. Date of Death Month D	ay Year	3. Time of Death
	/Medic		TERESA		CEO			10	4 04	6:30 AM
	Examin	er	4a. Facility Name (If not institution, give	4 1 1 0	1.	()	r Location of Deatl	h 2	County of Deat	h 101
			North any				DURNIE If Under 24 Hrs.	1	nne fin	unati
	Funeral		5. Social Security Number 6. S 2: 3-36-36-51	ex □M 2 DF 7. Age (In)	rrs. last birth	Months Days	Hours Min.	(Month, Day, Year	9. 810	hplace (State or Foreign
	Director		Usual Residence of Decedent	0	<u>۔ </u>			1-24-19	37	
]	A	1	10a. State 10b. County	10c.	City, Town	or Location				10d. Inside City Limits
	f sh	ō	MD Anne Aru	ınde1	Glen H	Burnie				1 ☐ Yes 2 🔀 No
	289	rec	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
	Geath with the Maryand ms 23a or 28a-f show	Funeral Director	7803 Winborne Dri	Lve, #C		21060			USA	
1	ms 2	nera	11. Marital Status	12. Was Decedent Ever i	n U.S.	13. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
	44	Ē	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 X No		1 ☐ Yes 2 No		to Rican, etc.)	Black, Whit	e, etc. white
500	e sin	by	3 Widowed 4 N Divorced	If Yes, Give Year or Dates:	- 100	TLI Yes 241 No	Specify:	8	Specify:	WIIICC
ָרָ מ	within /z hours after ene. then "neturel", or ite he wedter Exemine	Completed	15. Decedent's Ed (Specify only highest gra	ducation	16a. D	ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	oation during most of wo	rkina 16b.	Kind of Business	Industry
7	. Le	npl	Elementary/Secondary (0-12)	College (1-4or 5+)	- ' <i>i</i>		d)	de	partment	store
N.	e med within al Hygiene. i other then vent, the Me	S	11			clerk	1 40 14 4 4 14	me (First, Middle, Maide	- 0	
and		Be	17. Father's Name (First, Middle, Last) Willard Hall					ne (First, Middie, Maide nn Fifer	n Sumame)	
<u> </u>	matic e	유								
Ma	s 1 and 2 should I Health and Mer Item 27 is marke other treumatic		19a. Informant's Name/Relationship (Mrs. Ann Fifer /	**				ural Route Number, City 104 , $$ Glen $$ B		
o, •	Tand Health		20a. Method of Disposition						ocation - City or	
_	m O		1 ☐ Burial 2 ☐ Cremation 3 ☐	Tremoval from State		Disposition (Name of crematory or other pla ake Cremat			evensvil	
	artmen ortent; injury		 4 □ Donation 5 □ Other (Specifical Service Licental Service		nesape					
Бант	permit. Page Department of Importent; if any injury or once.		1 May 1 h	11 -	364	22. Name and Addre	Si	ngleton Fun Len Burnie l	eral Hom	ne P.A.
			23a. Part 1. Enter the disease, or com	nlications that caused the	death. Do no				ID 21001	Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		1 -	ng, odon do odroid	o or reophatory arroon		Interval Between Onset and Death
F	hysician /Medical		disease or condition resulting in death)	a. Chron		mg de	sease			1072
	Examiner			Due to (or as a cor	sequence of	IF	1)		Valani
		<u>a</u>	Sequentially list conditions,	b. Die to (or as a non	MBCINISHINGS OF	50	mys/			3- 3/3
	nsit	E L	Sequentially list conditions, I any, leading to trimediate cause. Enter Underlying Cause (Disease or injury							
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a cor	sequence of):				
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	leath certificate attending phy ifor use as the			V						
X Q Q	death certifica e attending ph id for use as th	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre	egnancy	• 			23d. Date of del	ivery
ň	d for	cla	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 ☐ I		3 ☐Ectopic pregnanc 5 ☐ Other (specify) _	У		Month	Day Year
2	that the de led by the a detached	hys	9 Unknown	9□ Unknown						
٠, ح	The law requires that the ite has been signed by the bage 2 should be detached.	by Physician/Med	Part II. Other significant conditions of	contributing to death but no	resulting in t	he underlying cause gi	ven in Part I.	23e. Did tobacco	use contribute to	the cause of death?
Hecords,	quire an sig uld b						-	1 Yes	2□No 3□Pr	obably 4 Unknown
ပ္သ	s bec	Completed						24a. Was an		stopsy findings available
Ä	te ha	E O						autopsy performed? 1 Yes 2 N	death?	completion of cause of
		a	25. Was case referred to medical				26. Place of De	ath (Check only one)	7,2,700	
	> 07 77	O B	examiner? 1 ☐ Yes 2 ☐ №	Hospital: 1 Inpatient	2 ER/Outp	atient 3 DOA Ot	her: 4 🗆 Nursing H	Home 5 Residence	6 ☐Other (Spe	cify)
0	g Phy er thi	T in	27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Tir	ne of 28c. Inju	ry at	28d. Describe how inj	ury occurred	
Division	kttending death. ctor; After y the funer	atlo	Natural 5 Pending 2 Accident investigatio		.,		Yes 2 □ No			
<u> </u>	f or Attend after death Director:	iffic	3 ☐ Suicide 6 ☐ Could not be determined		At home, farr	n, street, factory, office		28f. Location (Street a City or Town, Sta		ıral Route Number,
Ξ	pitel or A ours after herel Direc filled in by	Certification:		, , , , , ,						
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director; After completely filled in by the fune.	edical	29a. Certifier (Check only 2 Medical Example 1	nysician: To the best of my miner: On the basis of exam	knowledge,	death occurred at the ti	ime, date and place	e, and due to the cause(s) and manner as	stated.
	To the H within 24 To the F complete	ledi	one)	and manner stated.						
	within To the	Σ	29b. Signature and title of certifier	1.		29c. Licen	se number	29d. D	ate signed (Mont	n, Day, Year)
				ony		D-	5220	7	01251	04
1.			30. Name and address of person who		(Item 23a) (T	ype, Print)	(A) (D)	STREET	1.205	MD 21225
1)		21 Date filed (Month Day Year)	SHARMA 32/Registrar's S	5 J	VIJ. HM	VOUCE	317001	13174	- U H(24)
	Sta	ite	31. Date filed (Month, Day, Year)	1 /15 cure	ignature 4	Ann. V.	1			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 004 34573 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 1, 2004 **Physician** Phyllis Jean Anderson 10:31а м /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Carrol1 Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 10, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2√0 F 213-26-2730 75 Yrs. Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or Items 23e or 28a-f show treumatic event, the Modical Exam artifulation notified at Sykesville MD Carroll 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 6408 White Rock Road 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 7 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Controller Accounting 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 Is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) Be THeodore Edward Weber Goldie Lake 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6408 White Rock Road Sykesville, MD 21784 Mr. Jack Anderson (Spouse) 20a. Method of Disposition

14 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Baltimore Natl Cemetery 11/5/04 Baltimore, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL, PA (Box 195) Suan of Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, as the t IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for (Day in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physiclen: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 🗌 Yes this 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After Year) 1 Natural
2 ☐ Accident 5 Pending investigation efter death.

Director: Aff
of in by the fur 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗌 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide 24 hours a Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the within 2 29c. License number 29b. Signature and title of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLE ROAD NAGANNA GOURISHANKAR NOV 0 3 2004 22. Registrar's Signature State Registrar

			1 - For State Registrar	State of	Maryland / Dep <i>Ce</i>	artment of F	lealth and Death	Mental Hy	giene 20	04 34574
	Physici /Medic		1. Decedent's Name (First, Middle,	A	strow			2. Date of De Month	ath Day	Year 3. Time of Death
<i>F</i>	Examir	er	4a. Facility Name (If not institution, 94603 BENSON AVE 5. Social Security Number 6	ENUE	iber) 7. Age (In yrs. last birthday)	4b. City, Town, or	BALTIM(ORE	4c. County o	BALTIMORE
. 30 25	Funeral Director		057-01-3158 Usual Residence of Decedent	1 M 2 D F	95 Yrs.	Months Days	Hours Mir		1909	9. Birthplace (State or Foreign Country)
	e Maryland Ba-f show	Director	10a. State 10b. County	BALTIMOR	10c. City, Town or Le	ocation	BALTIMO	ORE		10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	th with th	al Dire	10e. Street and Number 4603 BENSON AVE	ENUE		10f. Zip Code	21227		10g. Citizen of Wh	hat Country? USA
920	urs after des al', or Itams Exertiter m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Armed For	2 X No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 💢 No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or No irto Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc. WHITE
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-f show many njury or other traumatic event, it a Medical Exertic at runal be rectified at DDGs.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12		(Give	dent's Usual Occupa skind of work done of DO NOT use retired	during most of w	orking	16b. Kind of Bus	iness/Industry
	t be filed ntal Hygi ed other event, I	Be	17. Father's Name (First, Middle, La	ist)	LEW	LJ	18. Mother's Na	ame (First, Middle,		
Maryland	12 should h and Men 7 is marke rraumatic	J.	19a. Informant's Name/Relationship MYRA FECTEAU /		19b. Maili	ng Address (Street a	and Number or F			
altimore, I	pernit. Pages 1 and Department of Health Importent: If item 27 any njury or other tr pncs.		20a. Method of Disposition 1 🛱 Burial 2 □ Cremation 3	□Removal from S	20b. Place of Disponentate	matory or other plac	е)	Date	20c. Location - C	City or Town, State
Baltir	permit. P Deportme Importen any njuri		* 4 □ Donation 5 □ Other (Spe 21. Signature of uneral Service Lie		110 2	MEMORIAL 2. Name and Addres 8900 REIS	ss of Facility			
8760,	Physician and physician and physician and physician and the buttal-transit	dical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Southfally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. A S Due to (c) C.	used the death. Do not en ich line. OICATION or as a consequence of): CMENTER or as a consequence of): or as a consequence of):	ter the mode of dyin			rest,	Approximate Interval Between Onset and Death 2 days
P.O. Box 68	ne death certifi the attending phed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1□Live bii	int at time of death 5	Ectopic pregnancy Other (specify)			23d. Date Monti	
	quires that the signed by all did be detacted		Part II. Other significant conditions Alzheimers	s contributing to dea	ath but not resulting in the u	inderlying cause give	en in Part I.	23e. Did to		oute to the cause of death?
Vital Records,		Completed by	Congestive	Hear 1 Vas	t failur	e Visease)	24a. Was autop perfor 1 □ Yes	rmed? pri	ere autopsy findings available or to completion of cause of ath?
Division of Vita	To the Hospitel or Attending Physician: The iwithin 24 hours after death. To the Funerel Director: After this certificate hat completely filled in by the funeral director, page	atlon: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat	28a. Date or (Month	patient 2 ER/Outpatier I hijury Day Year) 28b. Time o	f 28c. Injury Work	or: 4 ☐ Nursing	eath (Check only on Home 5 X Residence 128d. Describe h		
Divis	tel or Attus s after de el Directo	Certification;	3 Suicide 6 Could no 4 Homicide determine	289. Place	of Injury - At home, farm, sti g, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (S City or Tow	Street and Number m, State)	or Rural Route Number,
	the Hospi in 24 hour the Funer prietely fill	Medical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the laminer: On the base and manner	pest of my knowledge, deat sis of examination and/or in er stated.	vestigation, in my op	ointon, death occ	e, and due to the curred at the time, o	cause(s) and mann date and place, an	ner as stated. d due to the cause(s)
)	To with To COUT	2	29b. Signature and title of certifier	SUS		29c. License	54.33	7	29d. Date signed ($0/31$)	(Month, Day, Year)
			30. Name and address of person when Richard (3) 31. Date filed (Month, Day, Year)	s. Stef	of death (Item 23a) (Type.	00 325		arting	Gate C	NE MD + 21797
	Sta Registr		NOV 0.3 20	1	gistrar's Signature	Sporks	/			

		-	For State Registrar	State of	Maryland /	•	artment of Hertificate of L			Reg. N2 0	04	34575
	Physicia	an	Decedent's Name (First, Middle	, Last)					2. Date of De Month	Day	Year	3. Time of Death 9:15 AM
	/Medic	al -	4a. Facility Name (If not institution)	alley	(har)		4b. City, Town, or	Location of De	Octobe		2004 by of Death	
	Examin	er	Haclone Hos CA	tal Conte	V		0 11	1010		N/A		
	Funeral Director		5. Social Security Number 220–36–0871	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. last b		If Under 1 Year Months Days	If Under 24 H Hours M		th Year) 1938	9. Birth Cou SOU	place (State or Foreign ntry) 1th Carolina
	pu >		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or to	ocation					10d. Inside City Limits
	fanyla r shov	ō	Maryland N/A			Ltim						1 XYes 2 □ No
	death with the Maryland rms 23e or 28a-f show rms the maiffied at	rect	10e. Street and Number		Dai		10f. Zip Code			10g. Citizen o	What Cou	ntry?
	th with	al D	901 Cherry Hill	Road Apt.	367		21225			USA		
Maryland 21215-0036	after or ite	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	Armed For	2 X No	13.	Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)		ack, White	can Indian, , etc. _ack
5-0	72 hc	eted	15. Decedent (Specify only highes	t's Education st grade completed)	16	a. Dece	dent's Usual Occupa kind of work done d DO NOT use retired,	ation Juring most of v	vorking	16b. Kind of	Business/Ir	ndustry
121		Completed by	Elementary/Secondary (0-12)	College (1-							Hospi	tal
2	Hygi Hygi ther nt. 1	e Co	12 17. Father's Name (First, Middle,	Last)		vuls	ing Assis		lame (First, Middle			
an	od a b	To B	James Chavis					Arl	etha McL	eod		
ary	s 1 and 2 should be if Health and Mental I item 27 is marked oother treumetic eve		19a. Informant's Name/Relations				ng Address (Street a					
	7		Sheila Romaine	Bailey / d			Sea ull A	venue l	Baltimore	, Mary 1		
3altimore,	Page nent o int: If iry or		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	pecify)	State cemet	Cre	matory or other place ematory In	c. 11,	02/04	Baltin	ore,	Maryland
Bal	permit. Departn Importe any inju		21. Signature of Funeral Service Thomas Greg	or		2	2. Name and Addres Tremation 199 Freder	1CK ROS	ad Baltim	ore, Ma	rylar	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that ca only one cause on ea	aused the death. De	o not en	ter the mode of dying	g, such as card	iac or respiratory a	ırrest,		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Ven	Kichlar	77	brillahon	1.			-	
	Examiner			My	or as a consequence	J OI):	n Grich	on				8 MINAKE
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequenc	e of):	1					8 MINUTES
	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Dua to	or as a consequence	1/6	y Mise	ase				Wijeas
80	be ex icien a burial		,	200.00	01 43 4 001100400110	o o .,.						
687	tificate ig phys as the	edical		0.								
.О. Вох	ne death cer the attendir hed for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐Live b	come of pregnancy irth 2 Fetal dea ant at time of death own		□Ectopic pregnancy □ Other (specify)				ate of delive	very Day Year
٥	res that the igned by be detact	by Ph	Part II. Other significant condition	ons contributing to de	eath but not resulting	g in the	underlying cause give	en in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
rds	w requires been sig should bo	ed b							- 1	Yes 2□No	3 🗌 Pro	bably 4 12 Unknown
Vital Records,	The law requate has been page 2 should	Completed							24a. Wa auto perf 1 🗆 Yes		were aut prior to c death? 1 \(\sum \text{Yes}\)	opsy findings available ompletion of cause of
/ita	iclen: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:			-t 2Cl DOA Othe	or	Death (Check only			
	Physi this c	. To	1 ☐ Yes 3 ☐ No 27. Manner of leath	28a Date	npatient 2 ER/6	Outpatie	INT 3 DOA	4 Nursin	g Home 5 Res 28d. Describe	idence 6 C how injury occ		ify)
on	ding I th. : After funer	tlon	1 Natural 5 ☐ Pendir	/Adopt	h, Day Year)	Injury	Worl	k? Yes 2 □ No				
Division of	Atten	ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At home, ng, etc. (Specify)	farm, s	treet, factory, office		28f. Location	(Street and Nur	nber or Rui	ral Route Number,
Ö	tel or rs afte el Dir	Certification;	4 Notticide	Dullan	ng, etc. (Specily)							
	To the Hospitel or Attending Physiclen: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only 2 Medical one)				nvestigation, in my o	pinion, death o		, date and place	and due	to the cause(s)
	To 1 To 1	M	29b. Signature and title of certifie	Yaym	ul mo		29c. License	9 number 9 5 2 0	22	Ochob		Day, Year)
	(0		30. Name and address of person	no completed laus	se of death (Item 23a		, Print) 1th Hanove	r Stree	et Baltin	ore, Ma	rylar	nd 21230
	St Regist	ate rar	31. Date filed (Month, Day, Year, NOV 0 3		gistrar's Signature		Sport					

		State of Maryland / Department of State Registrar Certificate of			iene 2004	34576
		1. Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
Physicia /Medic		John F. Bacigalupa		Month /	Day /200	10:35AM
Examin			or Location of Death	•	4c. County of Dea	
		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea	ir If Under 24 Hrs.	8. Date of Birth (Month Day, April 2	N / /	thplace (State or Foreign
Funeral Director		215-94-1103 1M 2 F 40 Yrs. Months Days	s Hours Min.	April 2	(27, 1964)	viaryland
g .		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. fnside City Limits
/anyla	ō	Md. N/A Baltimore				1≹Yes 2 No
r 28e-	rect	10e. Street and Number 10f. Zip Code		1	0g. Citizen of What C	ountry?
th with	ai D	1416 Weldon Place South 2121	1			USA
ar dea tems	Funeral Director		f Hispanic Origin? (Spec iban, Mexican, Puerto R	cify Yes or No- tican, etc.)	14. Race - Am Black, Whi	
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Ither than "neturel", or items 23a or 28a-f show ant, the Madreal Examinar must be ricillised at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No If Yes, Give 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🛣 No	o Specify:		Specify: W	hite
72 hou		15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work don	upation	a	16b. Kind of Business	Vindustry
Men.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	e during most of working red)		Plumbing	
filed v Hygie thert		12 Plumber 17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	<u> </u>	
at yidilid XIXIDOOOO should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other then "naturelt, or items 23a or 28e-f show umatic event, the Medical Examiner must be mailled at	To Be	Robert Bacigalupa	Jacqueli		Kinnon	
Designation (e.g., Mary grants of I.Z. 13-0030) permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mandal Hygiene. Integration: It flem 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other treumatic event, the Modeal Examinal must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Mr. Robert Bacigalupa/ Father 19b. Mailing Address (Street 4412 Bucha	_{et and Number or Rural} nan Ave. Ba			
or He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other p.	,		20c. Location - City of	Town, State
DESILLING Permit. Pages Department of it mportent: If It any injury or o		'4 □ Donation 5 □ Other (Specify) Hilltop Service			Towson, M	d
Darti. Departinitmporte any inje		21. Signature of Funeral Servine Licensee 22. Name and Add RUCK TO 1050 Yo	ws on Funera rk Rd. Tows	1 Home, son, Md.	Inc. 21204	
H _ T		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line.	ying, such as cardiac or	respiratory arre	est,	Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. [Warrand Len	northage			
Examiner		Due to (or as a consequence of):	l em -			
sit s	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			AU	
OX OX OU, certificate be executed rding physician and use as the burial-transit	Examiner	that initiated events resulting in death) Last C			MOTON ES	MINER
ate be e hysiciar the buria	dical	d			MEDICAL E	
intiffication of physical parts of the physical	60	IF FEMALE:		Ch n	PANONED BY	
death cer death cer ie attendin ad for use	Physician/M	23b. Was decedent pregnant in the past 12 months?	ncy	CENTIFICATIO	23d. Date of de Month	livery Day Year
the de	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 5 ☐ Other (specify)				
Cords, F.C. BOX or wrequires that the death certificate been signed by the attending planduld be detached for use as a	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.		pacco use contribute t es 2 ⊠No 3 □ P	o the cause of death?
ecords, law requires as been sign 2 should be	letec			24a. Was a		utopsy findings available
* 0 - 2	Completed			autops perform 1 Yes 2	ry prior to death?	completion of cause of
r VI(ZI r ysicien: Th is certificate director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death			
F S F	2	1 Pyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			ence 6 Other (Spe	ecify)
ding th.	tion	1 Netural 5 Pending (Month, Day Year) Injury W	ork? □Yes 2⊠No		ugle a	olision
UNISION I or Attending after death. Director: Afte	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specity)	e 2	1 1-1	reet and Number or F	
ital or rel Dir led in	Cert	Street		5. Ex	eter St.	[Larbard
DIVISION O To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the tuneral	ledicai	29a. Certifier (Check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the check only one) 2 Medical Examiner: On the bast of my knowledge, death occurred at the check only one)				
To th comp	ž	29b. Signature and title of certifier 29c. Lice	nse number		9d. Date signed (Mon	th, Day, Year)
~		I buly to MD AL	141764	55	11/1/04	,
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			, ,	
Sta Registi		31. Date filed Manth Day, Year 2004 32 Registrar's Signature & Apart				

			1- State of Maryland / Department of Health and M Certificate of Death	1ental Hygier		34577	
	Physici /Medic		1. Decedent's Name (First, Middle, Last) JOHN THOMAS BENNETT, JR.	2. Date of Death	36 2 ¹ 114	3. Time of Death	
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. Ci	ie x	4c. County of Death	Rundel lace (State or Foreign	
	Director		219-10-3762 1XXM 2□F 79 Yrs. Months Days Hours Min. Usual Residence of Decedent	8. Date of Birth (Month, Day, Yea 7/13/1925	FLOR	lace (State or Foreign try) IDA	
	Maryland	tor	10a. State 10b. County 10c. City, Town or Location MD ANNE ARUNDEL GLEN BURNIE		1	0d. Inside City Limits 1 ☐ Yes 2X No	
	h with the	Funeral Director	10e. Street and Number 10f. Zip Code 204 5TH AVENUE S.W. 21061	10g. (Citizen of What Coun	try?	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Menial Hygiene. I Health and Menial Hygiene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Madical Examination rust by notified at		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2XXMarried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Year or Dates: WWII	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.	
21215-0036	filed within 72 he Hygiene. ther than "natui int, the Madical	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of work) ife. DO NOT use retired) ELECTRICIAN	ing	Kind of Business/Inc	·	
	2 should be filed within and Mental Hygiene. Is marked other than aumatic svent, the M	en Sumame) ENS					
Maryland	y or Town, State, Zip	Code)					
	Pages 1 and nent of Health int: If item 27 iry or other tr		MRS. MARGARET L. BENNETT/ WIFE 204 5TH AVE. S.W., GLEN 20a. Method of Disposition XXBurial 2 remation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		MD 21061 Location - City or To	wn, State	
Baltimore,	permit. Pages Department of Important: If ii any injury or o				NERAL HOM	E P.A.	
	Physician /Medical		23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):			Approximate Interval Between Onset and Death	
8760, <	Examiner	licai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):				
.O. Box 68	that the death certifice ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of delive Month	ry Day Year	
Fair II. Durier significent contributing to death but not resulting in the underlying cause given in Part I. 239. Did tobacco use contribute to the cause of the							
sion of	ding J. After fune		27. Manner of Death 1 Avatural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 1 Yes 2 No	28d. Describe how in			
Division	after Dire	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, Sta	and Number or Rura. ite)	Route Number,	
	To the Hospital within 24 hours To the Funeral completely filled	Medical (29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, a composition of the composition o	ed at the time, date a	ind place, and due to	the cause(s)	
)	To the within To the Comp	Me	29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (item 23a) (Type, Print) of the Driver 31. Date filed (Month, Day, Year) 32. Registrar's Signature	29d. C	tober 2	Day, Year) 2014	
	10		30. Name and address of person who completed cause of death (tell) 23a) (Type, Print) State Drive	e, Glen B	urnie, M.	aryland 21061	
	Sta Registi		NOV 0 3 2004 32 Registrar's Signature				

State of Maryland / Department of Health and Mental Hygiene 2004 34578 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Thomas Ε. Branham November 2004 6:20 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 32 Hampton Road Linthicum Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Year)
July 5, 1923 **Funeral** 9. Birthplace (State or Foreign Months Days Hours Min 218-14-3002 1 X M 2 □ F 81 Virginia Yrs. Director Usual Residence of Decedent 10a State 10b. County 10c, City, Town or Location item 27 is marked other then "naturel", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Anne Arundel Linthicum Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21090 32 Hampton Road United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 h and Mental Hygiene. 7 Is marked other then "na Elementary/Secondary (0-12) College (1-4or 5+) Equiptment Operator JC Parrot 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Bennett Branham Minnie Virginia Johns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Importent: If item 27 Rose Long, companion 32 Hampton Road Linthicum, MD. 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ö Meadowridge Memorial Park 11-5-04 Elkridge, MD □Donation 5 □ Other (Specify) Ambrose Funeral Home, Inc. 22. Name and Address of Facility 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ARTERIOSCLEROTIC Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERTEN 100VS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine HOLESTEROL requires that the death certificate be executed ELEVATET Due to (or as a consequence of): burial-1 attending physician a for use as the burial Box 68760 Physician/Medicai the as t IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death Month Day Year 5 Other (specify) P.O. 1 the 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Be Completed by >TEN 6SCS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2 1 Yes Division of Vital the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 Homicide within 24 hours a To the Funerel D 29a. Certifiei 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check only one) 29b. Signature and title of pertified 29c. License number 29d. Date signed (Month, Day, Year) NOVERIBER 2-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FISHERZ RICHARI ENNINGTON 32. Registrar's Signature State 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene

			Certificate of Death	Reg. No. 2004 345/9
		1. Decedent's Name (First, Middle, Last)	D	2. Date of Deeth Dey Year 12:15pm
	Physician /Medical		BAGINSKI	NOVEMBER OF 2004
Z	Examiner	4a Fecility Neme (If not institution, give street end number)	4b. City, Town, or I	,
		18 CRAFTON RD.	ESSEX	Baltimore
	Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) Dec. 6, 1918 Maryland
	Director	219-01-2788 Usuel Residence of Decedent	85 Yrs.	Dec.6,1918 Maryland
	Bud ♣ ■		c. City, Town or Location	10d. Inside City Limits
	Aaryli C cho		Essex	1 ☐ Yes 2 🖫 No
	the h	10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
	with with	18 Crafton Road	21221	USA
	ifer death with the Ma r ifems 23a or 28e-fe niner must be notified Einners! Director	2 11. Marital Status 12. Was Decedent Ever		
	ther c	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No		
8	ors a	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☐ No Specify:	^{Specit} White
21215-0020	led within 72 hours a ygiene.	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupation	16b. Kind of Business/Industry
7	e e e	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)	
7	ed wi	12th	Homemaker	ownhome
밀	tal H doth	17. Fether's Name (First, Middle, Last)		ne (First, Middle, Maiden Sumerne)
<u>×</u>	Ment Ment Ment Ment Ment Ment Ment Ment	Joseph Roth		a SAltyciak
Maryland	2 sh and land raum	19a. Informant's Name/Relationship (Type, Print)		iral Route Number, City or Town, State, Zip Code)
ຜົ	l and lealth m 27 her t	Margaret Rasinski/daugh	Ob. Place of Disposition (Name of	altimore MD 21221 Date 20c. Location - City or Town, State
ō	it of H	1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crematory or other place)	11/5/04 Baltimore MD
Ë	permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If ten 27 is marked other than "naturel", or items 23a or 28e-f ehow anay injury or other traumatic event, the Medical Examiner must be notified at ancy indicate. To Re Commission In Emersor	4 Donation 5 Dotner (Specify)		TT/ 5/ OF Barermore IB
Baltimore,	Demi Depa Impo any Ir	21. Signature of Funeral Service Licensee		onnellyFuneralHomeofEssex
_	20240	1. /em Conne		Baltimore MD 21221
-		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not enter the mode of dying, such as cardiac	c or respiratory arrest, Approximate Interval Between Onset and Death
	Physician /Medical	Immediate Cause (Final		onder and board
1/4	Examiner	disease or condition resulting in death) a. ATRIAL	- ARRHYTHMIA	+ MONTHS
			to (or as e consequence of):	1 4-0-
	uted ansit	b. AORTIC	to (or as a consequence of):	6 YEARS
o	exec	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying		10 10 3
68760,	ysicie	cause (Disease or injury that initiated events Due	to (or es a consequence of):	10 YEARS
89	certificate be executed ding physician and isa as the bunal-transit	resulting in death) Last		i I
	th cer andir r usa	d		
-	death he attar led for u	Part tl. Other significant conditions contributing to death but no	t resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
<u>О</u>	v requires that the death of been signed by the atten should be deteched for u	DEMENTIA		1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
	ras the			Oth Manual Association
5	requi			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause
ခြင	8 8 8			of death?
<u> </u>	The catal			1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
Division of Vital Records,	Physician: rthis certific ral director,	25. Was case referred to medical examiner? Hospital:	Other	ath (Check only one)
ō	Physic this corral dire	1 Inpetient	2 EN Outpetient 3 DOA 4 Nursing H	ome 5 A Residence 6 Other (Specify) 28d. Describe how injury occurred
<u>o</u>	ding h. After fune	1 Minetural 5 □ Pending (Month, Dey Year 2 □ Accident investigation	ar) 28b. Time of 28c. Injury at Work? M 1 Yes 2 No	
S	Attending ir death. ector: After by the fune	3 Suicide 6 Could not be determined 28e. Plece of Injury -	At home, farm, street, factory, office	28f. Location (Street and Number or Rural Route Number,
ă	tal or Attending P rs aftar death. sl Director: After t led in by tha funera	4 ☐ Homicide determined building, etc. (S _i	pecify)	City or Town, State)
			r knowledge, death occurred at the time, date and place	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	the Hospi in 24 hou the Funer aplataly fil			
	Son Teith	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
J,	1 1/2	funda Hangasl	n D0062032	NOVEMBER 01, 2004
6	118	30. Neme and address of person who completed cause of deeth	(Item, 23e) (Type, Print)	LE, BALTIMORE, MD 21224
		JENNIFER HAYASHI, MD 5505 31. Dete filed (Month, Park, Year) 32. Register's 3	HOPKINS BAYVIEW CIRC	LEWALLINGKEIMD 21994
	State Registrar	NOV 3 - 2004	Signature & Joseph	

			1 - For State of Maryland / Dep	artment of Health and Mental rtificate of Death	Hygiene 004	34580		
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) JOSEPH	BAUER 2. Date Mont		3. Time of Death 4 1407 M		
7	Examin		4a. Facility Name (If not institution, give street and number) Bayview Medical Center	4b. City, Town, or Location of Death Baltimore	4c. County of Dea	4c. County of Death n/a		
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 183-44-2201 18 M 2 F 58 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date Months Days Hours Min. Fex	of Birth 9. Birth (h, Day, Year) 46 Ma	thplace (State or Foreign ountry) ryland		
	faryland show	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L MD Baltimore Es	ocation SeX		10d. Inside City Limits 1 ☐ Yes ※☐ No		
	with the N a or 28a-1 be notiff	Direct	10e. Street and Number 4609 Wilbur Road	10f. Zip Code 21221	10g. Citizen of What C	ountry?		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Madral Examinating that be notified at	by Funeral Director		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ▼ No Specify:	or No- c.) 14. Race - Am Black, Whi	te, etc.		
21215-0036	within 72 hou ane. than "natural ne Modical E	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tril	edent's Usual Occupation be kind of work done during most of working DO NOT use retired) Ck Driver	16b. Kind of Business Hatland	Vindustry Express		
73	e d la	To Be Co	7th 17. Father's Name (First, Middle, Last) William C. Bauer	18. Mother's Name (First, M Lillian I	Middle, Maiden Sumame) L. Behrens			
	5 5 E G		19a. Informant's Name/Relationship (Type, Print) Paula Jo Bauer/daughter 5 J	ing Address (Street and Number or Rural Route I Norham Court Balti				
altimore,	00		20a. Method of Disposition 1	osition (Name of matory or other place) wCrematory 11/1/04	20c. Location - City of Baltimore			
Balti	permit. Pages Department of Important: If ii any injury or o		21. Signature of Funeral Service Licensee	2. Name and Address of Facility Connel 300 Mace Ave Balt	lyFuneralHo imore MD 21	meofEssex 221		
	Pnysician ₁		23a. Part1. Enter the disease, or complications that caused the dead. Do not en shock, or heart failure. Lier only one cause on each line. Immediate Cause (Final disease or condition.	iter the mode of dying, such as cardiac or respira	tory arrest,	Approximate Interval Between Onset and Death 2 Hours		
	/Medical Examiner		resulting in death) Due to (or as a consequence of): ADULT RESIDENTER	y DISTRESS SYNDRON	ME	3 DAYS		
<u> </u>	ate be executed hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):					
68760,	tificate be on physician as the buri	edical 8	d					
P.O. Box (Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physician and be the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M		□Ectopic pregnancy □ Other (specify)	23d. Date of de Month	livery Day Year		
ds, P.	uires that t signed by ld be detai	by	Part II. Other significant conditions contributing to death but not resulting in the ISCHEMIC CAIDIOMYOPATITY	underlying cause given in Part I. 23e.	. Did tobacco use contribute t	o the cause of death?		
l Records,	The law requir ate has been si page 2 should i	Completed	LIVER FAILURE	24a.	autopsy prior to performed? death?	utopsy findings available completion of cause of		
Vita	yslcien: The I is certificate ha director, page	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check	only one)] Residence 6 □Other (Spe	-: ()		
Division of Vital	iding Phys th. : After this funeral di	tlon; To	1 Yes 2 No	THE SELECTION 4 NORSHIP TOTAL	cribe how injury occurred	ocity)		
Divisi	o afte	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office 28f. Loca City	tion (Street and Number or R or Town, State)	ural Route Number,		
	To the Hospital or within 24 hours afte To the Funeral Dir. Completely filled in 1	Medical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or in and manner stated.					
	To t To tl	Σ	29b. Signature and title of certifier Matthus Top M.D.	RES-000	29d. Date signed (Mon	* * *		
1	118		30. Name and address of person who completed cause of death (Item 23a) (Type MATTHEW PIPELING 600 NORTH WOLF	. Print) FE STREET BALTIMORE				
Ì	Sta Registi		31. Date filed (Month, Day, Year) NOV 3 - 2004	rester .				

State of Maryland / Department of Health and Mental Hygier 34581 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2004 OCTOBER 29 MARY CECELIA BEECHER 9:56 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** GENISES ELDERCARE -- HAMMONDS LANE BROOKLYN PARK ANNE ARUNDEL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Oate of Birth (Month, Day, Year) APRIL 7, 1915 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2XX 212-10-4875 89 MARYLAND Director Usual Residence of Decedent 10a. State 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits ANNE ARUNDEL 1 ☐ Yes 2/CXNo Completed by Funeral Director GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 11 QUEEN ANNE ROAD 21060 II.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 No Specify: 3 Xidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be file frient of Health and Mental Hy tant: If Item 27 is marked oth jury or other traumatic event Be JOSEPH RUEHL ٩ LOUISE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA J. PETERSEN - DAUG. 1327 HOWARD ROAD, GLEN BURNIE, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or GLEN HAVEN MEM. PARK 11/1/2004 GLEN BURNIE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility FINK FUNERAL HOME, PA KELLY GREGORY FINK #MO1148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition Stage **Physician** Dementia disease of condition resulting in death) End /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a nonsecuence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ♠No 9 ☐ Unknown director, page 2 should be detached t 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tyes 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending Injury 24 hours after death. Funeral Director: A 1 □ Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only To the ! within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D53462 WD ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add Moness Oakwood Road Glen Burnie, mD JUde am D 7845

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day

Year)

Baltimore. Maryland 21215-0036

Box 68760.

P.O.

Records,

Division of Vital

32. Registrar's Signature

Physicia /Medic		1. Decedent's Name (First, Middle, La Andrea	_	eanett	:e	Brow	√n−S	Sear	les	Octob	er ^{Day}	29 2 [°] C	ຶ່ງ 2:15a
Examin		4a. Facility Name (If not institution, giv				4b. City, To						County of D	
		Stella Maris H 5. Social Security Number 6.5		TOWSON		If Under 1		If Under		8 Date of Birt			Birthplace (State or Fe
Funeral Director			***	50	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 08 2	y, Υθατ) 4	54	PA
Mo Tal		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City L
a-f sh tiffied	ctor	MD Balti	more	R€	eiste	ersto	vn_						1 □ Yes 2⁄2
or 28 De no	Funerai Director	10e. Street and Number	#100			10f. Zip C		126			-	en of What	
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nal Hygiene. Id other than "naturel", or Itams 23a or 28a-f show event, the Medical Ever in er roust be notified at	by Fun	1 □ Never Married 2 □ Married	Armed Force 1 ☐ Yes X If Yes, Give Year or Date	s? XNo	1	If Yes, specif		Specify:	, Puèrto P	city Yes or No- tican, etc.)			White, etc. Black
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al Hygiene. I other than "		12th grade 17. Father's Name (First, Middle, Last	4yrs		Tra	anspo			r's Nam <i>e</i>	(First, Middle,	_		Center
i and Mantal H is marked of reumetic ever	To Be	James B. Brown								Robin			
s mar		19a. Informant's Name/Relationship			19b. Maili	ng Address (Street ar	nd Numbe	er or Rural	Route Numbe	er, City or	Town, Stat	re, Zip Code)
of Health and Man litem 27 is marks r other treumatic		Ida H. Brown-	Mother					St.		6 Ree			
ent of He nt: If iter ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		ate cen	netery, cre. Nhite	esition (Name matory or oth Chai	er place oe 1	1	1/5/	104			or Town, State
Department of Importent: If it eny injury or once.		21. Ignature of Funeral Service De	nsee		2	rial danged March 1300 T	Address	H We	st Ave,	Balt	imo	re, M	4d 21215
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ng phy as the	ed	IS CELLA S					_						
in the farm requires that the obsain estimates the has been signed by the attending physologie 2 should be detached for use as the	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 【 No 9 ☐ Unknown		n 2 ∏ Fetald it at time of dea	eath 3[Ectopic prec Other (spec					2	3d. Date of Month	delivery Day Yea
and by detac		Part II. Other significant conditions	contributing to deat	h but not result	ing in the u	nderlying cau	rse dinei	n in Part I.		23e. Did to	obacco us	se contribut	e to the cause of deat
n sign	ed by									1 🗆 ነ	/es 2[]No 3□] Probably 4 🛣 Unk
ate has been si page 2 should I	Completed										sy rmed?	prior death	autopsy findings ava to completion of caus h? Yes 2 \(\sum \text{No} \)
	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o	2 X No ne)		
this cer al direc	은	1 ☐ Yes 2 🛣 No	Hospital: 1 □ Inp		R/Outpatie					e 5 □ Resid			Specify) HOSPI
After Anner	Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not the			lab. Time o	М		at ? 'es 2 🔲	No	8d. Describe h			
4 hours after death Funerel Director: tely filled in by the	Certific	3 Suicide 6 Could not to determined	28e. Place of	Injury - At hom , etc. (Specily)	e, farm, st	reet, factory,	office		2	8f. Location (S City or Tow		Number or	r Rural Route Number
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within 24 To the F complete	Σ	29b. Signature and title of pertifier				290,	7	number	25			signed (M	onth, Day, Year)
1											/ -	1	//

DHMH 17 Rev 1/2001

2:15 a.m.

OCTOBER 29, 2004

ANDREA SEARLES

					State of	Marylan		artment of rtificate of		Mental Hy	gien 2 () Reg. No.	04	34583
	- · ·		1. Decedent's Name (/	First, Middle, Les	st)	-			-	2. Dete of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Kenneth	Warf	ield	Bove	r			October			1003 AM
>	Examir		4e. Facility Name (If no						4b. City, Town,	or Location of Death	4c. County		
1			909 Moore	c Mill 1	Deo S				Bel Ai	r	Harfo	ord	
	Funeral		5. Social Security Num	ber 6. S	ex	7. Age (In yrs.	lest birthday)	If Under 1 Yea Months Devs	r If Under 24 H	Irs. 8. Date of Birt			ace (State or Foreign
	Director		212-58-870)1 1	MM 2□F	5	2 Yrs.	WOTHIS Doys	i iouis ivi	Apr. 10	, 1952	Mary	land
	D .		Usual Residence of De	ecedent						· ·			
	how i			0b. County			ty, Town or Lo	cation				10	d. Inside City Limits
	Ma 9-f	ᅙ	Maryland	Harford	l	Be.	l Air						1 ☐ Yes 2 No
	± 28 €	i e	10e. Street end Number					10f. Zip Code			10g. Citizen of	What Count	ry?
	h wil	E	909 Moore	s Mill 1	Road			210	14		USA		
	deed E	Funeral Director	11. Marital Status		12. Was Dece Armed For	dent Ever in U	,S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	14. Rac	e - America	
0	after A	T	1 Never Married	2 Married	1 ☐ Yes	2-17 No		1 Tes, specify Cu 1 □ Yes 2 No		eno mican, etc.)		ck, White, e	IC.
02	el', e	b	3 ☐ Widowed 4 [If Yes, Giv Year or De	etes:		ILL TES ZOLING	эрвспу.		Specif	v: Wh:	i+o
21215-0020	72 hours after deeth with the Marylend neturel', or Nerns 23a or 28e-f show deal Examiner must be notified at	Completed by	(Specify	5. Decedent's Ed only highest gra	lucation		16e. Deced	tent's Usual Occu	pation during most of a	vorkina	16b. Kind of B		
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þ	e the file	Be	17. Fether's Neme (Fir	rst, Middle, Last)					18. Mother's N	lame (First, Middle,	Maiden Suman	10)	
Maryland	Aente Aente de la principa de la pri	To	Muller	Warf	ield	Boyer			Olive	(nmn) Di	ıPuv	
aر	Short and a short		19a. Informant's Name				19b. Mailir	ng Address (Stree		Rural Route Numbe			Code)
	nd 2		Lauren Bo	ver - W	ife		909 M	oores Mi	11 Road	Bel Air	. Marvla	and 21	1014
ē,	te He		20a. Method of Dispos	sition			Plece of Dispo	sition (Neme of netory or other pl		Date	20c. Location		
Baltimore,	permit. Peges t and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Heelih and Mentel Hygiene. Important: If item 27 is marked other then "neturel", or items 23a or 28e-f show any injury or other traumatic event, the Modical Examiner must be notified at 2008.		1 ☐ Burial 2 🛣 4 ☐ Qonation 5			state	-	-		11 4 04	_		
≣	ertm.		21. Signal re of Funer			HI	TITOD	Service Name end Add	ess of Facility	11-4-04			
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			23a. Palt1. Enter the shock, or heart fa	ailure. List only	plications that ca one ceuse on e	aused the deat ech line.	h. Do not ent	er the mode of diy	ing, such es card	ac or respiretory e	rest,		Approximate Interval Between Onset and Death
	Physician			1	M		N /) . 1	+ '			1	Oriset and Death
1	/Medical Examiner		Immediete Ceuse (Fin disease or condition resulting in death)	iai	a. ///	yoca,	rollok	mon	chow			1	
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	the e	ysic	Part II. Other significa	nt conditions o	ontributing to de			nderfying cause g	iven in Pert I.	23b. Did 1	obacco use co	ntribute to	the cause of death?
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of Vital Records,	Attanding Physicien: The lav ir death. ector: After this certificete hes by the funeral director, page 2	Be	25. Was case referred exeminer?	to medical						Deeth (Check only o	ne)		
>	nysic als ce	2	1 Yes 2 □ No	·	Hospital: 1 □ Ir	npatient 2 🗆	ER/Outpatier	t 3LI DOA		Home 5 Resid	lence 6 🗆 Oth	er (Specify)	
0	g Pt tertt		27. Manner of Death	5 Pending	28e. Date of	t Injury h, <i>Day Year</i>)	28b. Time of Injury	28c. Inj	ury et ork?	28d. Describe I	now injury occur	red	
<u>.</u>	ath. r: Af	atic	2 ☐ Accident	investigation)			M 1[Yes 2□No				
Division	Atte er de ecto by th	titic	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	286. Place	of Injury - At he		eet, factory, office)	28f. Location (S City or Tox	Street end Numb	er or Rurel	Route Number,
Ö	taion saft ai Dir	Certification:					,,						
	To the Hospital or Attending Physicien: The Is within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	cai	29a. Certifier 1	Certifying Ph	ysicien: To the	best of my kno	wledge, death	occurred at the	ime, date end pla	ce, and due to the	ause(s) and ma	anner as ste	ited.
	he H in 24 he Fi	edicai	one)	Wedical Exem	and mann	er stated.	MION BINGOI III	resugation, in my	opinion, death of				
	To t To t	Σ	29b. Signature and title	e of certifier	11			29c. Licer	ise number		29d. Date signe	d (Month, D	ey, Year)
			Penas	61. VI	Ann. M	1. DONE		Do	14200	5 (Defoles.	30 2	1914
	11.		30. Name end eddress	of person who	completed ceus	of death (Item	n 23a) (Type,	Print) .					
	10		RERNARI	J. Yyl	(NA ME	DIVE	7018	HOLABI	RU AVE	BALTO	Md Zi	222	
5	Sta	ite	31. Date filed (Month,	Day, Year)	32. Re	egistrar's Signa	ature	-					
	Registi	rar	MOA	0 3 2004	5	war	B	Sparks	1 .				
DH	IMH 16 Rev 6/9	5			1		/	R					

State of Maryland / Department of Health and Mental Hygien 2004 34584 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** TORSY 2500 Marv Bonner /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Arunde North Arundel 1. slen Dur Hesp:to If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number . Age (In yrs. last birthday) Funeral Months Days Hours 1□M 2**X**F Yrs. 14,1929 Marvland Director 215-24-0273 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show treumatic event, the Medical Exercises must be notified at 1 ☐ Yes 2 No Baltimore Anne Arundel Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 U.S.A. 21226 8225 Parkway Road or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 BNo Specify: Specify: Baltimore, Maryland 21215-0036 à White 3 ⊠Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Importent: If item 27 is marked other than "nat any injury or other treumatic event Coflege (1-4or 5+) Elementary/Secondary (0-12) Anne Arundel Co, Schools Teachers Aide 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helen Burke Earnest William 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8104 Bonner Lane Pasadena, Maryland 21122 Robert G. Bonner (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 Cremation 3 Removal from State Holy Cross Cemetery 11/05/04 Brooklyn Park, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 3 menths Physician 0 on creas ancer /Medical Due to (or as a consequent of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be exec Due to (or as a consequence of): Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day Month ō 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 KNo 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: Injury 1 Natural 2 Accident 5 Pending 2 1 No after death. 1 Tes investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier 24285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Glea Bornie MD 2661 301 Hospita Am Chales & Wilas MMD North Awadd 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

BONNER, Mary

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 34585 Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Month 3. Time of Death Dev Vaai **Physician** Sr. October 31, 2004 Brown 6:00 A.M. James Watkins /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3601 Greenway Apartment #510 Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5 - 31 - 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ kM 2 □ F 212-03-4987 89 Director Maryland Usuel Residence of Decedent death with the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Md. 1 Ves 2 □ No Baltimore Director 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 3601 Greenway Apartment #510 21218 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Armed Forces? 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. parmit. Pages 1 and 2 should be filed within 72 hours after Department of Haatth and Mantal Hygiena. Important: If Item 27 is marked other than "natural", or ite any injury or other traumatic event, the Modical Examina 1⊠ Yes 2□ No Army If Yes, Give Year or Dates: WW II 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yas 2XXXIo Specify: Specify: White ٥ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banker 12 5+ Loyola Federal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å William Henry Brown Florence Horney Friend 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen D. Corasaniti 3601 GREENWAY Apt #511 BAltIMORE, MARYLAND ZIZIS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 11-3-04Baltimore, Maryland Parkwood Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility Charles S. Zannino Licensed Mortician P.O. Box 23942 Baltimore, Md. 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 4 acis Examiner Due to (or as a consequence of): Examine law requires that the death certificate be axecuted attanding physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) signed by the at Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Chimic Disease -2 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? paga 2 has 2 No 1 ☐ Yes ≱ No 1 ☐ Yes or Attending Physician: Be 25. Was cese referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 Yes 2 No 2 ER/Outpatient 3 DOA this Irector: After this by the funeral of 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide To the Hoepital o within 24 hours af To the Funeral Di complataly filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 11-2-04 D23076 KICHARD DIAMOND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

NOV 0 3 2004

3730

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Rel

Falls

Sparks ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 1 - For State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month ADELINE L. BUSKIRK 200 /Medical 4c County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 05Pita KOSEDO R If Under 1 Year If Under 24 Hrs. 50 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 3/30/ 9. Birthplace (State or Foreign Country) MARYLAND 5. Social Security Number **Funeral** 1 M 2 KF Director 213-26-7203 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits if item 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic event, the Mactical Examinar must be notified at 1 ☐ Yes 2 No Directo BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 6304 GOLDEN RING ROAD USA by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 KNo 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, The Madia 2005. Elementary/Secondary (0-12) College (1-4or 5+) 12 WESTVACO PAYROLL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MARTHA KARP MICHAEL ADAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 HOLLY CIRCLE BALTIMORE, MD. 21221 MRS. NANCY JESTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 & Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 11/1/04 BALTIMORE. MD. 21. Signature of Funeral Service Libensee RACZOROWSKI ACIITUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE. MD. 23a. Part1. Enter the disease, or complications that caused the teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Houte Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease in july that initiated events resulting in death) Last Due to (or as a consequence of): Examiner if or Attending Physician: The taw requires that the death certificate be executed and redeath.

Director: After this certificate has been signed by the attending physician and a link by the tuneral director, page 2 should be detached for use as the buriat-transit in by the tuneral director, page 2 should be detached for use as the buriat-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Pes 2 No 1 Pres 2 No 25. Was case referred to medical examiner?
1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral D 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ranklinchatham eprive Baltimore, MD State NOV 03 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 4 34587 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 0 Ethel L. Bergquist 8:00 A 31, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2708 Page Drive Dunda1k Baltimore 7. Age (In yrs. last birthday) 88 yrs If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 200 210-16-3778 Director 4/24/1916 Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits or Itams 23s or 28a-f show other traumatic avent, the Modical Executive noted by notified at FL 1 Yes 2 No Director Pascot Port Richey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 7821 Tropican Drive Funeral 34668 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White by If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then." Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Lawrence Florence Rogers 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanna Herring/Daughter 2708 Page Drive Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ₺ Burial 2 Cremation 3 Removal from State injury or Meadowridge ' 4 ☐ Donation 5 ☐ Other (Specify) 11/3/04 Baltimore , Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton- Matthews F.H. 'n 2134 Willow Spring Road Dundalk, MD 21222 inlications that cause the heath. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cluss on each line. 23a. Part1. Enter the dise se, or shock, or heart fa are. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinome **Physician** Bowel /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) 9. Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy this certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼No Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death. To the Funaral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and title of certifie D16801 2200 Baltmore MD 21237 9103 F Sallare Por. 31. Date filed (Month, Day, Year) egistrar's Signature NOV 0 3 2004 Registrar

04-6993 B.K.S MARY K. CHEEZU

I K. CHEEZUM	For State		epartment of Health and	Mental Hygier	2001 21500
	Registrar 1. Decedent's Name (First, Middle, Li		Certificate of Death	Reg. N	3. Time of Death
Physician /Medical	Mary	к.	Cheezum		ay Year
Examiner	4a. Facility Name (If not institution, gir 717 DRUID PARK I	ve street and number) _AKE DRIVE APT.708	4b. City, Town, or Location of Deat BALTIMORE CITY	h 4	Ic. County of Death
Funeral Director		5ex 7. Age (In yrs. last birts 1	nday) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) Md.
pu s	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		
Maryli f eho	Md. NA		Baltimore		10d. Inside City Limits 1 X Yes 2 □ No
r 28e-	10e. Street and Number		10f. Zip Code	10g. (Citizen of What Country?
23a o	717 Druid Par	k Lake Dr. Apt	.708 21217		USA
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28a-f show soft, the Madical Examiner must be notified at the Madical Examiner must be notified at e.e. Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer □ Yes 2♥ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
15-003	15. Decedent's E	ducation 16a.	Decedent's Usual Occupation	16b.	Kind of Business/Industry
and 21215-0036 be filed within 72 hours all hal Hygiene. dother than "naturel", or event, the Medical Exam Be Completed by F	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	(Give kind of work done during most of wo life. DO NOT use retired)	rking	Third of Dubiniossal Mostly
21 set the set	G.E. D.		School Teacher		y of Baltimore
E e g g b s	17. Father's Name (First, Middle, Las William) Butt		ne (First, Middle, Maide erine	en Sumame) Riley
Maryland 2121. nd 2 should be filed within th and Mental Hygiene. 27 is marked other than " 27 is marked other than " To Be Compile	19a. Informant's Name/Relationship		Mailing Address (Street and Number or Ru		
re, Ma			020 Foxcroft , Balt		21221
Baltimore, permit. Pages 1 ar Department of Hea mportent: if teminy injury or other pres.	20a. Method of Disposition 1 Burial 2 Cremation 3		Disposition (Name of crematory or other place)	Date 20c.	Location - City or Town, State
Page ment tent: flury o	'4 Donation 5 Other (Speci	Themoval from State		3-04 Ba	altimore, Md.
Baltimore, Maryla permit. Pages 1 and 2 should Department of Health and Men importent: if them 27 is marke any injury or other treumatic sonce.	21. Signature of Funeral Service Lice	p Warred	22. Name and Address of Facility March F.H. East	Balti 1101 E. N	more, Md. 21202 Torth Ave.
Dhuaisian	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ot enter the mode of dying, such as cardiac		Approximate Interval Between Onset and Death
Physician /Medical	disease or condition resulting in death)	a. MYFELTENSIVE AT	MOSCIBLETIC CMO	MSCUM	DISEASTE
Examiner	Esquentially list conditions.	b.			
executed in end ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence o	ř):		
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c 68 artifica ing ph as the	IF FEMALE:				
ecords, P.O. Box 6 law requires that the death certifi as been signed by the attending 2 should be detached for use as	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
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cords w require been sig should b				1 ☐ Yes 2	2 0 3 Probably 4 Unknown
The The page				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
of Vital Physicien: The Physicien: The this certificate ral director, page To Be Co	25. Was case referred to medical examiner?	Hospitale		th (Check only one)	
Of N Physi rthis o ral dire	1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp 28a. Date of Injury 28b. Ti		ome 5 Residence	7
On ding h. Afte tune	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) In	me of ury 28c. Injury at Work? M 1 Yes 2 No	200. Describe now inju	ary occurred
Division c tel or Attending P is after death. al Director: After t led in by the funera Certification;	3 Suicide 6 Could not be determined		n, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, le)
Hosp 14 hour Funer tely fill	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exam	nysician: To the best of my knowledge, miner: On the basis of examination and and manner stated.	death occurred at the time, date and place for investigation, in my opinion, death occu	, and due to the cause(s	s) and manner as stated. Id place, and due to the cause(s)
To the within 2 To the comple	29b. Signature and title of certifies	10	29c. License number		ate signed (Month, Day, Year)
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3	My E. al		ype, Print) enn Street, Baltimon	re, Marylan	d 21201
State Registrar	51. Date filed (Nonth, Day, Year) NOV 0 3 2	32. Registrar's Signature	b space		

			For State	State of Marylan	d / Department of I Certificate of			711116	34589
	°. Physicia		Registrar 1. Decedent's Name (First, Middle, La		- Commonto or		Reg. N 2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, gin	ve street and number)	4b. City, Town,	or Location of Death	October	30, 2-00/ 4c. County of Death	12 FORM
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	Funeral Director			Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthpl	lace (State or Foreign try)
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	with the	Director	10e. Street and Number 7813 Curnerst	ne Ma.	10f. Zip Code	atul.	10g. (Citizen of What Coun	try?
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920	urs afte el', or it	by Funerai	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 👿 No			Specify: Pul	Y K
15-0	natur	leted	15. Decedent's E (Specify only highest gi	Education ade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of worki	ng 16b.	Kind of Business/Inc	dustry
21215-0036	d within giene er then	Completed	Flementary/Secondary (0-12)	College (1)4or 5+)	Whole	Sale		Clother	q
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene 1 Health and Mental Hygiene 1 Health and Mental Hygiene 2 Is marked other then "nature!", or Items 23e or 28e-1 show item 27 Is marked other then "nature".	o Be (17. Father's Name (First, Middle, Las	v)		18. Mother's Name	(First, Middle, Maid	en Surname) (J
Mary	2 should be and Mental Is marked c	-	19a. Informant's Name/Relationship	ype, Print)	19b. Mailing Address (Stree	1 11-	1.1	y or Town, State, Zip	Code)
	s 1 and 7 Health Item 27 other tr	1	20a. Method of Disposition	Daughter) 20b. P	lace of Disposition (Name of emetery, crematory or other pla	stone wa		Location - City or To	wn, State
Baltimore,	Page nent o ant: If ary or		1 1 Marial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		rrisin Enrest	11.8	-04 Or	vings Mi	16,MD
Ball	permil. Par Department Important: any injury		21. Signature of Funeral Service Lice	ensee	22. Name and Addr	ess of Facility Vou	ighne Gre Banda 118	town Mr	rusnes.
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	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence.	dence or):				
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on of	ding PI h. After ti funera	tion:	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)		ry at 2 ork?] Yes 2 □ No	28d. Describe how in	jury occurred	
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	To the Hospitel within 24 hours a To the Funerel I completely filled	Medical	one)	miner: On the basis of examina and manner stated.		<u> </u>			
	0 1 ₹ 5 Ø	7	29b. Signature and title of certifier	Junes he		1950 2		Date signed (Month, I	
L	171		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	KORTH	WAT HE	Soin 36 The Varylind	Canton
	Sta	ate	31. Date filed (Month, Day, Year)	32. Redistrar's Signa	ture A Long	1000411:	s could h	racylino	~123
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			State of Maryland / Department of Health and Mental Hygien 2014 34590
			1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
1	Physicia		ANNA W CARGO 10 26 ZOCY 544 AM
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
			Bon Secours HOSPITAL BALTIMORE, MD 2123 M/A
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 1 M 2 F 7. Age (In yrs. last birthday) 1 Months Days Hours Min. 2 Month, Day, Year) 2 V Country 4 Proceedings of the process of the p
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	yland how		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	Ba-f si	ctor	MD NIH Baltimore 12 Yes 2 No
	with the	Funeral Director	10e. Street and Number 10g. Citizen of What Country?
	death	nera	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or othar traumatic event, the Medical Examitter must be multified at once.	þ	1 Never Married 2 Married 3 Wildowed 4 Divorced Specify: 1 Yes 2 No Specify: Specify
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Maryland	2 shot and N ls ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Yown, State, Zip Code)
	and 2 ealth m 27 i		ErNEStine Scott, 4501 Kateland Aus Buer M 2120'
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) BEULAH LAND 1/1/04 IVOR, VA
alti	ermit. epartn poorts ny Inju		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Howell Funeral Introduction
	20529		Willie Ettowell & - 4600 UBERTY I FUL BURD MP 21207
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Onset and Death
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	To the Hospital or Attan within 24 hours effer deat To the Funeral Diractor: completely filled in by the	Medical	29a. Certifier (Check only one) 29a (Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
	1		D603473 10/26/04.
	'')		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DONOVAN B. PAKIES, 2000 W Bultmore ST Bultmore MO 21223
	Sta	ite	31. Date filed (MT) Pay Year) 32. Begistrar's Signature
	Registi		South
			/ / WILL

State of Maryland / Department of Health and Mental Hygiene 34591 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Terrance Patrick Cahill October 23, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1048 Marleigh Circle Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec 11, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 95 Yrs England Director 217-40-1625 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: if item 27 is marked other than "naturat", or items 23a or 28a-1 ahow ury or other fraumatic event, it is Medical Escripta man to notified at 10d. Inside City Limits Baltimore 1 ☐ Yes 2√ No Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1048 Marleigh Circle 21204 <u>USA</u> Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by white 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) police dog trainer law enforcement 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) unk Be ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ware/daughter 1048 Marleigh Circle Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Depertment of H Importent: If its any injury or of once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Significant of Lineral Signature Licenses Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Interval Between Onset and Death one cause on Immediate Cause (Final disease or condition Physician resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 XNO 3 Probably 4 □Unknown as been si 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed: page certiticate 1 Yes 2 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 25 No 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation death the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) l in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital filled tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/28/04 run h wo P32543 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Unls ST Baltinere 6701 MANIC STROMBONG 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Elizabeth J. Clarke October 28, 6:00 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7906 Wynbrook Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□M 2₩F Year) 1907 Maryland 97 Yrs. Director 218-07-5570 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits itam 27 is markad othar than "natural", or Items 23a or 28a-f show other traumatic evant, its Madical Experiment at 1 ☐ Yes 2 ☐ No Funerai Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7906 Wynbrook Road 21224 u.s.A. death 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after a and Mental Hygiene. is marked other than "natural", or Itel 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 X Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9th Grade Factory Worker Ice Cream Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Ruleu Rowena Hines-Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 is in any injury or other traum <u>once</u>. Mr. Joseph Bopp (son-in-law) 1 Ginford Place, #204, Baltimore, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ` 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 11/02/2004 Baltimore, Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death ARTERIOSCUERETIC **Physician** ARDIO VASCULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, Physician/Medical nding phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 252 No 1 ☐ Yes 1 Yes 2∏ No To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 Accident 5 Pending within 24 hours after death. To the Funeral Director: A investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) abhitier 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of death 30. Name and address BAIN MORE 31. Date filed (Month, Day, Ye Year) 32. Registrar's Signature State Registrar

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Physician (Medical Examinor) Physician (Medical Examinor)		36		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not en	1	-	-	2		Interval Between
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Hnthony 2595 9:50 AM 28,2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3213 Rosway Court Glenelg Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 29 1919 5. Social Security Number Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday) **Funeral** 1 □**X**M 2 □ F 179-12-2378 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location orient: If item 27 is marked other then "naturel", or items 23a or 28e-1 ehow injury or other treumstic event, the Medical Examinar must be notified at 10d. Inside City Limits Md Howard Glenelg 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3213 Rosway Court 21737 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WWII 1 ☐ Yes 2 ☐ No Specify: Specify: white þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event. Elementary/Secondary (0-12) 12 College (1-4or 5+) U.S. Military computer programmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Anthony Cerar Mary Hribar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Kirby (daughter) 3213 Rosway Ct., Glenelg, Md 21737 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Arlington National Cem 12-15-04 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Daige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Lung innies me fas fatic Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physicien and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physicien detached for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Emphysima 054 3 ☐ Probably 4 ☐ Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 esidence 6 Other (Specify) ပ 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Manner of Death
 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 5 Pending investigation 1 TYes 2 Accident Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D30573 =10-29-64. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paturent Parkway Columbia Hozleyk MD 11065 KMin 1:410 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State o	f Marylan		artmen				lental Hyg	jiene 20	04	34!	596	
			Decedent's Name (First, Midd	le, Last)				-			2. Date of Dea	th		3. Time of	f Death	
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			1- For State of Maryland / Department	urtment of Health and Me tificate of Death	ental Hygier Reg.		34597
	Physici		1. Decedent's Name (First, Middle, Last) Margaret Isabel Ciarpella		2. Date of Death Month CTOBER	Day Year 27 2004	3. Time of Death
	/Medio		4a. Facility Name (If not institution, give street and number) Union Memorial Hospital	4b. City, Town, or Location of Death Baltimore		4c. County of Death	
	Funeral Director		5. Social Security Number 219-20-5455 6. Sex 1 M XX F 7. Age (In yrs. last birthday)	Months Days Hours Min	8. Date of Birth (Month, Day, Ye Jan 31, 1	ar) 9. Birthpl Count 1928 Mar	ace (State or Foreign try) yland
	yland		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo.	cation		10	Od. Inside City Limits
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	th with	al Dir	3700 Southern Avenue	21206	Tog.	Citizen of while Coun	USA
336	I within 72 hours after death with the Maryland liene. r then "neturel", or Items 23a or 28e-f show the Medical Evarifret riust be nutified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	Vas Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto R ☐ Yes XIXNo Specify:	cify Yes or No- lican, etc.)	14. Race - America Black, White, & Specify: W	
12-0	"netur	eted	15. Decedent's Education (Specify only highest grade completed) (Give	lent's Usual Occupation kind of work done during most of working DO NOT use retired)	g 16b	. Kind of Business/Ind	ustry
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	1 and 2 Health :		Janice Mays Daughter 722 20a. Method of Disposition 20b. Place of Dispos	Shawna Avenue		ennsylva Location - City or To	nia 1740
Baltimore,	Page: ment o ent: If ury or		Maryland 2 □ Cremation 3 □ Removal from State '4 □ Donation 5 □ Other (Specify)	l Veteran 11/1/	/04 Ga	rrison F	orest,MD
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Division	tel or Attend s after death el Director: , ed in by the f	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	et, factory, office	Bf. Location (Street City or Town, St.	and Number or Rural ate)	Route Number,
	To the Hospitel or Att. within 24 hours after de To the Funerel Direct completely filled in by the	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invalid and manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as sta and place, and due to	ited. the cause(s)
)	To t To t com	M	29b. Signature and title of certifier Anvita lane. MD	29c. License number AT 2438946-1		Date signed (Month, D	
	X		30. Name and address of person who completed cause of death (Item 23a) (Type, IANVITA PARHAR, 201 E. UNIV. PI	Print)			(1)
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature				
DH	MH 17 Rev 1/2	- 6	NOV 0 3 2004 Berus B	BOOKEN			

Roger Cannon 04-07001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend items 20 by 20 by 20 percentage 8370 1125 r040 vt Mental Hydian 8000 1

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	MAN		For State Registrar	-State of WK	arykandiya.	Certificat	e of L	eaith a n Death		Reg. No.	04	34598	
1	Physici /Medic		Decedent's Name (First, Middle, ROGER CANNO						2. Date of I	er 30, 2	.004ª	3. Time of Death	
	Examir		4a. Facility Name (If not institution, Johns Hopkins H	Mospital		Bal	timo			N/	ty of Death		
	Funeral Director		212-86-5753	6. Sex 7. Ag	e (In yrs. last bir 35	Yrs. If Under Months	1 Year Days	If Under 24 h	in. 8. Date of the second seco	Birth Day, Year) 24 1969	Cou	place (State or Foreign Intry) Aryland	
	e Maryland a-f ehow	ctor	Usual Residence of Decedent 10a. State 10b. County MARYLAND N/A		10c. City, Town	n or Location	3					10d. Inside City Limits 1 XYes 2 No	
	ath with the 23a or 28	Funeral Director	10e. Street and Number 257 S DALLAS	COURT		10f. Zip	21	231		10g. Citizen of U.S		intry?	
036	within 72 hours after death with the Maryland ene. than "natural", or Items 23s or 28s-f show the Marjical Ever'il at mail te muffied at	þ	11. Marital Status 1XXVever Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2XX If Yes, Give Year or Dates:		13. Was Dece If Yes, spe 1 \(\subseteq Yes		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or i erto Rican, etc.)	No- 14. Ra Bl	ack, White,		
Maryland 21215-0036	be filed within 72 hours after death with the Marylar Ital Hygiene. Id other than "natural", or frems 23s or 28s-f show of other than "natural", or frems 12s or 21st and event, the Medical Ever in set must be reclifted at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade 15. Decedent's Usual Occupation (Give kind of work done durit life. DO NOT use retired) CONSTRUCTION						working		16b. Kind of Business/Industry WINCHESTER HOMES		
yland 2	should be filed withind Montal Hygiene. It marked other than umatic event, Ing.M.	To Be C	17. Father's Name (First, Middle, L BERNARD R . EA	·						e (First, Middle, Maiden Sumame) NE G CANNON			
	nd 2 alth a 27 lg		19a. Informant's Name/Relationshi Geraldine Cannor 20a. Method of Disposition 1 XBurial 2 Cremation	n/Mother 3 □Removal from State	20h Place of		llas	Ct., 1	Baltimor Date	e, Maryl 20c. Location Balto	and 2		
Baltimore,	permit. Pages 1 a Department of Her Important: If item any injury or othe		4 □ Donation 5 □ Other (Sp. 21. Signature Fine Al. Sprice L	icensee		22. Name ar WILLIA 1206 W	M C I	s of Facility BROWN C PH AVEN	UE 1 101	H-East FUNERAL E. North	r . HOM		
	Physician /Medical		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	_a. Gunsitor	A 1	(2) tu-				arrest,		Approximate Interval Between Onset and Death	
	Examiner und transit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	c.	a contiagilienne i	,							
68760,	tificate be executed ig physician and as the burial-transit	Physician/Medical Ex		resulting in death) Last	Due to (or as	a consequence	of):						
.O. Box	The law requires that the death certif te has been signed by the attending page 2 should be detached for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp					ate of delivionth	ery Day Year	
Δ.	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to death b	ut not resulting ir	n the underlying c	ause give	in in Part I.		tobacco use cor		he cause of death?	
I Records,	(0)	Completed							24a. We aut per 1 X Yes	topsy rformed?		opsy findings available impletion of cause of	
of Vital	Physic this ce	n; To Be	25. Was case referred to medical examiner? 1 □ Yes 2 □ No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ry 28b. T	tpatient 3 DC	8c. Injury	r: 4 □ Nursin	7	v one) sidence 6 □Ot e how injury occu		(y)	
Division	al or Attending I s after death. I Director: After d in by the funer	Certification;	1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no 4 Homicide determin	ot be	rury - At home, fa			es 2 No	28f. Location	(Street and Num own, State) 43	ber or Rura	al Route Number,	
	To the Hospital or Attending the Funeral Direct Completely filled in by the	edical C	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: To the best xaminer: On the basis of and manner sta	of my knowledge f examination an	, death occurred	at the tim , in my op	e, date and pla inion, death or	ice, and due to th	e cause(s) and me, date and place,	anner as s	stated. o the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	sal. A	4		License			29d. Date sign		*	

State Registrar

31. Date filed (Month, Day, Year) NOV 0 3 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TACK M. TINS M.D. 111 F 2. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 0 0 1 34599 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 03:498 Tool MANIONAND 3 (/Medical ne (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Good Samartan Balt imorre Huintal If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/19/1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** M 2 F 220038576 Maryland Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other then "natural", or items 23s or 28s-f sho other traumatic event, it a Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore Overlea Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 541 St. Patrick Road 21206 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clothing Manufacturer Cloth Cutter 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event poses. Nicholas Cusimano Camille (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris C. Cusimano/ Wife 541 St. Patrick Road Overlea, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Bunal 2 Cremation 3 Removal from State 11/3/04 Lakeview Memorial Sykesville, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 6415 Belair Road Baltimore, Maryland 21206 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of bear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Ziemtha disease or condition resulting in death) /Medical Due to (or as a consequence of): Livrascular Disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year director, page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes No 3 Probably 4 Unknown Be Completed 24a. Was an autopsy performed? 1 Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? After this certificate 2 | No 1 TYes instruct ioz To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funerel Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A000 ERDHARAN MD. 21213 IAIN 22. Registrar's Signature 31. Date filed (Month, Day, Year) NOV 03 2004 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5:20 P M John A. Cronin Sr. /Medical October 31, 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3904 Bush Ct. Harford Abingdon 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Days Hours 1፟፟፟፟፟ M 2 ☐ F 212-22-7461 10/29/1925 Director 79 Maryland Usual Residence of Decedent with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Exantinar must be motified at MD Director Harford Abingdon 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3904 Bush Ct. 21009 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 窗 Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "nat any injury or other traumatic event, the Medica once. Elementary/Secondary (0-12) College (1-4or 5+) Purchasing Agent 10 Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernard Cronin Catherine Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Hayes/ Daughter 3904 Bush Ct. Abingdon, Maryland 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 Cremation 3 Removal from State Schwartz * 4 ☐ Donation 5 ☐ Other (Specify) 11/4/04 Baltimore, Maryland 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funer Service Licensee 6224 Eastern Avenue Baltimore, Maryland 21224 23a. Part1. Enter the disease or pications that caused the death. Do not enter shock, or heart failure. Just only one cause on each line. Onset and Death Immediate Cause (Final Physician metastanc years disease or condition resulting in death) /Medical Due to (or as a dome-quence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Cause (Disease or kijur that initiated events resulting in death) Last Due to (or as a consequence of): physician Box 68760 Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? certificate I 1 ☐ Yes 2 🔼 No Hospital or Attending Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) asaelan NOVEMBER 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8114 SAND PIPER CIRCLE BALTE Det. 21237 SIV SANKARI ASAILAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV **0 3** 2004 Registrar

		•	1 - For State of Maryla	nd / Department of Health and Me Certificate of Death	ntal Hygien	2111111 31.601								
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Anita Butler		Date of Death Month D	ay 7 2004 1144 Am								
	Examin Funeral			4b. City, Town, or Location of Death Ab. Lity, Town, or Location of Death I Under 1 Year If Under 24 Hrs. 8,	Date of Birth	c. County of Death N/A 9. Birthplace (State or Foreign								
	Director		161-28-3382 1□ M 2 M F 68 Usual Residence of Decedent	Yrs. Months Days Hours Min.	(Month, Day, Year AR 15, 19	936 Pennsylvania								
	aryland show	_		City, Town or Location Baltimore		10d. Inside City Limits 1 XYes 2 ☐ No								
	r 28a-f	recto	10e. Street and Number	101. Zip Code	10g. C	Citizen of What Country?								
	23a o	al D	325 S. Durham Street	21231		USA								
920	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ire Madical Examinal must be nutified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes ② No If Yes, Give Year or Dates:	U.S. 13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- an, etc.)	14. Race - American Indian, Black, White, etc. Specify: White								
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21215-0036	filed withir Hygiene. other than ant, Ine M	ошо	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Domestic								
	be filed ntal Hygid sd other evant, II	Be	17. Father's Name (First, Middle, Last) Robert Shields	18. Mother's Name (F		n Sumame)								
Maryland	2 should be and Mental is marked o	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural R	a Randik loute Number, City	or Town, State, Zip Code)								
	1 and 2 Health a tem 27 is		Linda Christina Butler/daughte	er 318 S. Durham Street	Baltimore	e, MD 21231								
nore	Pages 1 nent of H int: if iter		1 Burial 2 XCremation 3 Bemoval from State	Place of Disposition (Name of cemetery, crematory or other place) etro Crematory, Inc. 10/29		Location - City or Town, State								
Baltimore,	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or othar once.		21. Signature of Fun val Service Lisanese	22. Name and Address of Facility of	Maryland	d, Inc.								
			23a. Part1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	299 Frederick Road ath. Do not enter the mode of dying, such as cardiac or re		Approximate Interval Between								
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	/Medical Examiner		Due to (or as a conse	eq ence of): liver Disease	3	2 years								
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>	execute n and ial-tran	Examiner	that initiated events resulting in death) Last	equence of):		ayeurs								
8760,	icate be executed physician and s the burial-transit	dical	d											
Вох 6	leath certific attending p	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of preg			23d. Date of delivery								
P.O. B	that the death	hysicia	hysiciai	hysician	hysiciar	hysician	hysiciar	Physician/Me	hysiciar	hysiciar	in the past 12 months? 1			Month Day Year
Records, F	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	by	Part II. Other significant conditions contributing to death but not re	esulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?								
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Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 — Yes 2 No Hospital: 1 Ninpatient 2	26. Place of Death C		6 ☐Other (Specify)								
n of	ding Phys	on: T	27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Injury at Work?	I. Describe how inju									
Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	M 1 ☐ Yes 2 ☐ No home, farm, street, factory, office 28f.	Location (Street a	and Number or Rural Route Number,								
Div	ital or instantial or instanti	Certi	4 Homicide building, etc. (Spec	city)	City or Town, Sta	te)								
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, death occurred at the time, date and place, and nation and/or investigation, in my opinion, death occurred	due to the cause(at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)								
	with To 1	Σ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)								
	7		30, Name and address of person who completed cause of death (It		D II	ober 27, 2004 more, MD 21287								
			All Son Hobelmann 6 31. Date filed (Month, Day, Year) 32. Registrar's Sig	00 North Wolfe Street	Baltir	riore it is 21281								
	Sta Registi		NOV 0 3 2004	& Sparker										

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34602 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Francis Wilson Downey OCTOBER 31,2004 7:45P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A 524 N.CHARLES STREET BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days Hours **™** M 2□ F 87 Vrs Maryland Director 218-07-0723 AUG 1. 1917 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ahow drer coast be notified at 1 XYes 2 ☐ No Directo Maryland Baltimore N/A10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a 524 N. Charles Street 21201 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No WWII If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "naturat" Completed 15. Decedent's Education (Specify only highest grade completed) The Madical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 'Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accountant Oil & Banking Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 27 is markad of traumatic available Frank Duckett Edna Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ortant: If item 27 i t of Health Lutherville, MD 21093 Date 2 c. Location - City or Town, State 831 Janet Keller Grayson/cousin Jamieson Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. Metro Crematory, Inc. 11/01/04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses ²²Crame and Address & Facility of Maryland, Inc. Milwid McDonald McDonald 299 Frederick Road Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertensive Arteriosclerotic Cardiovascular Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed ding physiclan and resulting in death) Last Due to (or as a consequence of): burial-Box 68760, Completed by Physiclan/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year jo Month Day 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 5 Other (specify) o detached 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? (es 2 No 2 No 1 TYes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 X ther (Specify) SCENE Yes 2□No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

I Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 X medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. NOVEMBER 1,2004 30. Name and address of per n who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Mil JACK M. TITUS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 3 2004

State of Maryland / Department of Health and Mental Hygiene, For Stete Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 514 PM 20024 CCTONER James Joseph Dougherty III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 1473 Landis Circle If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yea April 15, Birthplace (State or Foreign Country)
 PA 7. Age (In yrs. last birthday, 5. Social Security Number Year) **Funeral** Months 1 M 2 F 1945 59 Director 219-44-6263 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ? Te marked other then "neturel", or Items 23a or 28e-f show treumatic event, the Medical Examinat must be notified at Bel Air 1 Yes 2X No Harford Md. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21015 United States 1473 Landis Circle Completed by Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. white Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ADivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) law enforcement deputy sheriff 18. Mother's Name *(First, Middle, Maid*en *Sumame)* Dorothy Denise Trenaman 17. Father's Name (First, Middle, Last) Be Mental Pages 1 and 2 should be James Joseph Dougherty, Jr. and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 145 Curds Way, Red Lion, PA 17356 Janet C. Rubenstein/sister f Health item 27 I other 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ot
once. cemetery, crematory or other place)
Garrison Forest Cem. 1 Burial 2 □ Cremation 3 □ Removal from State 11/5/2004 Owings Mills, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licent 22. Name and Address of Facility
Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Box 68760, Sylvanticate be executed Due to (or as a consequence of): physician ar Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an page 2 autopsy 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 € Residence 6 Other (Specify) 2 🗌 No 2 ER/Outpatient 3 DOA 2 After this funeral d 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification; nner of Death Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie OCTOBER 29, 20014 Name and address of per completed cause of de BALTO Not 2/222 AVE UKM NA 32. Registrar's Signature State Registrar NOV 03 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 34604 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** October 28 2004 3:40 A Charles George DiMattei, Sr. /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner HCR Manor Care Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months 1⊋M 2□F 212-12-2407 83 14, 1920 MD Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ahow tra Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? deeth with 403 Ordnance Road # 304 21061 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If thes, Give Year or Dates: 1944-45 Specify: white 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Construction other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fit ment of Health and Mental H tant: If item 27 is marked oft jury or other traumatic even 2 George J. DiMattei Elizabeth Aynes Pokarney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Ridge Road, Glen Burnie, Maryland 21060 Mr. Charles G. DiMattei, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. 1,2004 permit. Page Department o Important: If eny injury or Maryland Veterans Cem. Crownsville, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Der Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final HYPOKIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** n-EUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examiner The law requires that the death certificate be executed. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy jo in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CONGESTIVE FIMLURE HEART 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 1 Yes 2 □ No 2 -No Physician: Be 25. Was case referred to medical director 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No c 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: or Attending Injury 1 ENatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide hours after filled in within 24 hours a To the Funerel (Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Dey, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 STE 200 9186 PHILADELPHIA BALT.

DHMH 17 Rev 1/2001

State

Registrar

Baltimore, Maryland 21215-0036

72. Registrar's Signature

RD

H. ODIE, MD

DENNIS

31. Date filed (Month, Day, Year)

NOV 0 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:40 A.M. Ivie Deon Daniels October 30 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel North Arundel Hospital Glen Burnie 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year) 9/12/1910 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 223-20-6376 Yrs 94 Director NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f show event, the Medical Examiner must be notified at MD Anne Arundel Director Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 151 South Meadow Drive 21060 Items 23a USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or by 1 ☐ Yes 2X No Specify Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Tug Boat Captain Tug Boat Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Menta Importent: If tiem 27 1s marked any ligiury or other traumatic avonce. Cleveland Daniels Lillie Warren Daniels 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Fleckenstein 151 South Meadow Drive Glen Burnie MD 21060 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Glen Haven Cemetery 11/2/04 Glen Burnie, MD 5 O(her (Specify) 21. Signature of Puneral Ser 22. Name and Address of Facility Singleton Funeral Home P.A. ice Licens M01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** AND CURRONIE /Medical **Examiner** NOTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 Pregnant at time of death 5 Other (specify) signed t Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been sig. page 2 should b 2XN0 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1 Yes director Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 2 ER/Outpatient 3 DOA Sich 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. 4 hours after death.

-unerel Director: A

ety filled in by the fu 2 Accident investigation 1 Tyes 2 No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Funeral Dir 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

P.O. Box 68760.

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34606 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 31, 2004 **Physician** 18:35 Arlene Joyce Durham /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore
"Indar | Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Union Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Director 216-34-4959 66 05-07-1938 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "naturel", or items 23e or 28e-f show other traumatic event, the Musical Example in usit be notified at 10d, Inside City Limits 1 ☐ Yes 2 ☑ No Director Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3101 Bero Road 21227 Funeral U.S.A 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 XMarried ☐ Yes 2 ☐ No Yes, Give 1 ☐ Yes 2 ☐XNo Specify: Specify: White þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within il Hyglene, other then " Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Ownhome 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Pages 1 and 2 should be John Burke Margaret Hannenman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I Sharon Langford/Daughter 3524 Ridgeway St. Laureldale, PA 19605 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ö 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Importent: If eny injury or once. ö Meadowridge Mem'1 Park 11-05-2004 Elkridge, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Ambrose Funeral Home, Inc.
1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Licensee Colle 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease Physician Coronary YEARS disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner death certificate be executed ongestive that initiated events resulting in death) Last use as the burial-trar Due to (dras a consequence of) attending physician 2 WEEKS Physician/Medical monaru IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown The law requires that the à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy rmed? 2**X** No certificate 1 Yes or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 2 ER/Outpatient 3 DOA 1 Natural iilled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ☐ Accident nin 24 hours after deat the Funerel Director: 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number AT2438946E32 wann, M.D. October 31, 2004 appleted cause of death (Item 23a) (Type, Print) UNION MEMORIAL HOSPITAL

ann 201 E., University Parkway, Bultimore M.D 21218

Registrar

State

Maryland 21215-0036

Baltimore,

P.O. 1

Records,

Division of Vital

32. Progistrar's Signature

			For State Registrar	State o	f Maryland		artment of He tificate of D		Mental Hy	giene Reg. N	znai.	34607
H	Physicia	an	1. Decedent's Name (First, Middle,		_				2. Date of D Month Oct.	eath		3. Time of Death
	/Medic	al	Ruebe		Dugger		4b. City, Town, or L	ocation of Dea			2004 Year County of Death	
	Cxamiii	ei		cer Driv			Esse				Baltimo	
	Funeral			6. Sex	7. Age (In yrs. last	,,	If Under 1 Year Months Days					nplace (State or Foreign untry)
	Director		224-28-2699 Usual Residence of Decedent	† ∑ M 2□F	79	Yrs.	Widnitis Bays	TIOUIS WIII	April	18,	4 0 0 -	irginia
Ì	land wo		10a. State 10b. County		10c. City, T	own or Lo	cation					10d. Inside City Limits
:	Mary I-1 sh	tor	MD Bal	timore			Essex					1 ☐ Yes 2 ☐ C No
	or 284	irec	10e. Street and Number	-	10f. Zip Code			10g. Ci	tizen of What Cou	untry?		
	23a ustb	raic	9 Lancer Dri	ve			2122			US.	A	
	er der items	Funeral Director	11. Marital Status	Armed Fo		13. \	Vas Decedent of His Yes, specify Cuban,	panic Origin? (Mexican, Pue	Specify Yes or N to Rican, etc.)	0-	14. Race - Amer Black, White	
5	or, or	by F	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 1 🔼 Yes If Yes, Giv Year or D	/8		☐ Yes ¾☐X No	Specify:			Specify: Wh	ite
5	nature real		15. Decedent		1	6a. Deced	ent's Usual Occupati	ion		16b. K	ind of Business/li	
7	ithin "e.	Completed	(Specify only highest Elementary/Secondary (0-12)	Coltege (1-4or 5+)	life. I	kind of work done du 20 NOT use retired) Painter	ring most of wo	nking	Ulb	an Trac	ctor Co.
7	iled w Tygier Therti nt, fr		11th 17. Father's Name (First, Middle, L	acti						Admirán a		
	d be f ental h ced of c svs	o Be	Julius B.				'		me (First, Middle		i Sumame)	
2	shoul nd Me mark	2	19a. Informant's Name/Relationsh		1	19b. Mailin	g Address (Street an		E. Low		or Town, State, Zi	ip Code)
Ž	alth a alth a 27 is		Virginia Dug	ger / w:	ife		Lancer					
ב כ	of He of He fitem		20a. Method of Disposition	2 Pomovel from	20b. Place	of Disno	sition (Alama of	1	Data	20c. L	ocation - City or T	own, State
	Pag ment lant: i		`4 □Donation 5 □ Other (Sp	ecity)	HOTI		l I Ceme te	1	2/04	Bal	timore	MD
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importment: if fleam 27 is marked other then "naturel; or items 23a or 28a-f show any injury or other treumatic event, the Medical Examinat must be molified at once.		21. Signature of Funeral Service L	Conne	lly			Ace Av	e. Bali	timo	eralHo	meofEssex 21221
			23a. Part1. Enter the disease or of shock, or heart failure. List of	complications that only one cause on e	aused the death. I	Do not ente	or the mode of dying,	such as cardia	c or respiratory	arrest,		Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition resulting in death)	_a. A-+	erioscl	ero	tic Can di	ovasc	ulan D	Sec	ise	Onset and Death
I	/Medical Examiner		Todami,	Due to	(or as a consequen	ce of):						1
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to	ce of):							
	cate be executed physicien and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
Š	e exe	Ex	resulting in death) Last	Due to	(or as a consequent	ce of):						
	icate be executed physicien and s the burial-transit	dicai	V	d								
Y	ding lise as	/Me	IF FEMALE:	23c. If yes, out	come of pregnancy	,					ORA Data of deli-	
ă :	death e atter d for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live b	oirth 2 🗍 Fetal dea nant at time of death	ath 3	Ectopic pregnancy Other (specify)				23d. Date of deliv Month	Day Year
	t the by the tacher	hys	9 Unknown	9□ Unkn	own							
n n	es tha igned be de	by Р	Part II. Other significant condition	ns contributing to de	eath but not resultin	g in the ur	derlying cause given	in Part I.	23e. Did	tobaccoι	use contribute to I	the cause of death?
5	een si	ted							1 🗆	Yes 2	□ No 3 □ Pro	bably 4 Onknown
ט י	has b	Completed			· · · · · · · · · · · · · · · · · · ·				24a. Was	psy	prior to co	opsy findings available ompletion of cause of
ָ ב	n: Th ficete r, pag		05.146						1 ☐ Yes	ormed? 2 No	death? 1 ☐ Yes	2 No
5	s certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	npatient 2 ☐ ER/	Outpatien	Othor		ath (Check only		6 □Other (Speci	*
5 i	g Phy ter thii	1-	27. Manner of Death	28a. Date		b. Time of Injury	28c. Injury a Work?	ıt	28d. Describe			ry)
5	endin eath. or: Af he fu	atic	1 Natural 5 Pending 2 Accident investig	ation	, , , , , ,	,ary		s 2 No				
	ei or Att s efter de ii Direct id in by t	Certification	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin	200. Place	of Injury - At home ng, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (City or To	Street an wn, State	d Number or Run)	al Route Number,
:	To the Hospitie of Attending Physician: The law requires that the death certific within 24 hours elter death. Within 24 hours elter death. To the Funerel Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edical (29a. Certifier 1 Certifying (Check only one)	xaminer: On the b	best of my knowled asis of examination ner stated.	dge, death and/or inv	occurred at the time, estigation, in my opin	, date and place nion, death occi	e, and due to the urred at the time,	cause(s) date and	and manner as s I place, and due t	stated. o the cause(s)
1	To the	Σ	29b. Signature and title of certifier	11-	, 1		29c. License r	number		29d. Dat	te signed (Month,	Day, Year)
	. 2		1 may late	tette Mi	Deput	Υ	1186	67	(5070	sber 31	1,2004
)	11800		Philip Militell	ho completed caus	e of death (Nem 23.	а) (Туре, ! Ц:!!	erint) CT. Luth	enuille				
	Sta Registr		31. Date filed (Month, Day, Year) NOV 3	- 2004 ^{32. R}	egatrar's Signature	H.	CT. Luth		•			

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 34608 Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth 3. Time of Death Month Dev **Physician** AUREA E. DIAZ OCTOBER 28,2004 6:23 am /Medical 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Examiner FUTURECARE CANTON HARBOR BALTIMORE 8. Date of Birth (Month, Day, Year) OCT. 9, 1918 PUERTO RICO If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□ M 200 86 214-24-0171 Director Usuel Residence of Decedent with the Marylend 10c. City, Town or Location 10a Stete 10b County 10d. Inside City Limits 28a-f show ss 1 and Eshould be filed within 72 hours after death with the Maryle of Health and Mantal Hygiene. The Restrict of Rema 23a or 28a-1 show other treumstic event, the MacKoal Examiner must be notified at 1XYes 2□No Directo MD. N/A BALTIMORE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 603 S. ANN STREET U.S.A. 14. Race - American Indian, Black, White, etc. Funeral 21231 Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Maritel Status 1 ☐ Never Married 2 ☐ Married yland 21215-0020 PUERTO RICAN ¥ Yes 2□ No þ 3 NWidowed 4 □ Divorced Year or Dates: WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER 9 **H&S BAKERY** 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Department of Health and Mantal the important: If Item 27 is merked oth any injury or other treumstic event once. ANTONIO ORTIAZ MARIA JESUS LEON 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA DIAZ/DAUGHTER-IN-LAW 6114 CEDAR WOOD DR., COLUMBIA, MD. 21044 Pages 1 an Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XI Burial 2 ☐ Cremation 3 ☐ Removal from State OAK LAWN CEMETERY 11/01/04 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) ZZ Nam pod Address of Facility LILLY & ZEILER INC. FUNERAL HOME 21. Signature of Funeral Service Licensee 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between **Physician** hervodovite Heart Disease Immediate Cause (Final disease or condition resulting in death) /Medical Examiner en schero as Physician/Medicai Examiner or Attending Physician: The law requiras that the death certificeta be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and Ex 68760. Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 No 3 Probably 4 Unknown signed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 Yes 2DANG 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 3□ DOA this 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours aftar death.

To the Funeral Director: After t
completely filled in by the funer. Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of certified D11150 30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print) ELLWOOD AVE, BALTO, MD 21224 10RRES, MP 441 S. MELITO

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 3 2004

32. Registrer's Signature

		State Unpend Item Registrar Decedent's Name (First, Mrddle, Las		Ce	rtificate c	or Death	2. Date of Death	T	3. Time of Death
Physician	1	Lenora Rum	Diggs				October	28, 2004°	0112 A
/Medica Examine		a. Facility Name (If not institution, give	street and number)		4b. City, Town	n, or Location of Deat	h	4c. County of Death	
		Good Samaritan Ho		1 11111	Baltin If Under 1 Ye		To Day Anis	N/a	
Funeral Director	6	i. Social Security Number 6. S	ox 7. Age (H	n yrs. last birthday) Yrs.	Months Day			Year) 9. Birth	place (State or Foreig ntry) 4 · D
pur *	-	Jsual Residence of Decedent 10a. State 10b. County	16	Oc. City, Town or Lo	ocation				10d. Inside City Limit
death with the Maryland ms 23a or 28a-f ahow rinual be notified at		MD N/a		BA HIMON				0	1. ¶Yes 2 □ N
vith the Mar or 28a-f at be notified	= =	Oe. Street and Number		0	10f. Zip Cod	е	10	g. Citizen of What Cou	ntry?
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s after dealing of the state of	Dy rune	Marital Status Never Married 2	12. Was Decedent Eve Armed Forces? 1 Tyes 2 No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify O 1 ☐ Yes 2 ☑ 1	of Hispanic Origin? (S cuban, Mexican, Puerl No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White, Specify:	etc.
at di	neg r	15. Decedent's Ec	lucation		dent's Usual Oc	cupation ne during most of wo	rking 1	16b. Kind of Business/In	
_ * 2 -		Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use rea	tired)	i.i.ng		
Hygiene ther tha		17. Father's Name (First, Middle, Last)	0	1-054	en Cane	18. Mother's Nar	ne (First, Middle, M	Fuster CAR Maiden Sumame)	E
	0	Freddie Sampsin				Dien	& W1/50	3J	
th and Men 7 Is marke traumatic		19a. Informant's Name/Relationship	Гурв, Print)	19b. Maili	ng Address (Str			City or Town, State, Zip	o Code)
	76-	William Diggs		42	1 211		whomong M.		
permit. Trages I am Department of Heal Important: If item 2 any injury or other once.	1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of Dispo cemetery, cre	matory or other i	place)	/	20c. Location - City or To	
rtmen rtant: njury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer 		DRuid K	Idge Ce.	metery VII	3/04 1	Altimore Mone	flest
Departr Imports any inju		21. Signature of Funeral Service Licer	see					nurs MD 2	
	+	23a. Part1. Enter the disease, or companies shock, or heart failure. List only	plications that caused the						Approximate Interval Between
	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of right that initiated events resulting in death) Last	b. Due to (or as a co						
tificate ng physi as the	Tedical		d						
Hospital or Attending Physician: The law fequities that the death certain 24 hours after death. Funeral Director: After this certificate has been signed by the attending page 1 should be detached for use as the funeral director, page 2 should be detached for use as the funeral director.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 ☑ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 [4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	Ectopic pregna Other (specify			23d. Date of delive Month	ery Day Year
igned by the	y ru	Part II. Other significant conditions of	ontributing to death but n	not resulting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use contribute to t	he cause of death?
been sig	led r						1 🗆 Ye	s 2 No 3 Prol	babły 4 DUnkno
ate has be	Completed						24a. Was an autopsy perform 1 X Yes 2	/ prior to co led? death?	opsy findings availat impletion of cause of 2 No
certificate		25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one	9)	
this certific	0	1.X Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie				nce 6 Other (Specia	fy)
ith. :: After I	TION:	27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	njury at Work? □ Yes 2 □ No	28d. Describe hor	w injury occurred			
within 2 to see the completely filled in by the funer completely filled in by the funer	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury building, etc. (- At home, farm, st Specify)	reet, factory, offi	се	28f. Location (Str. City or Town,	eet and Number or Rura , State)	al Route Number,
To the Hospital or R within 24 hours after To the Funeral Dire completely filled in b	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of niner: On the basis of example and manner stated	amination and/or in	h occurred at the vestigation, in m	e time, date and place ny opinion, death occu	e, and due to the caurred at the time, da	use(s) and manner as s te and place, and due to	stated. o the cause(s)
within 2 To the comple	Σ	29b. Signature and title of certifier			29c. Lic	ense number	29	d. Date signed (Month,	Day, Year)
720		> Zahn.	ullah	Ah-	0.0	C.M.E.	0	ctober 28,	2004
i									
Ì		30. Name and address of person who	- A -	h (Item 23a) (Type, f		n Street,	Baltimore	e, Maryland	21201

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

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							Cer	tificate	e of l	Death			Reg. No.	0 4	0 18	010
			1. Decedent's Name (First, N	liddle, Last)	in 1		·-	•			2. Date of De Month	ath Day	Year	3. Time	e of Death
	Physicia /Medic		Marin	i 0 ,	1	Dulos	O					iO	30	2004	3	40 Pm
3	Examin		4e Fecility Neme (If pot instit	ution, give	street and nu	mber)			4	-		cation of Death		unty of Deatl		
			Futurecare	Home	boows					Ba1t	timo	re		N/A		
	Funeral		5. Social Security Number 2 1 3 - 28 - 4387	6. Se	× Эм 2 X F	7. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bird (Month, Da	th y, Year)	9. Birtl	place (Ste	te or Foreign
	Director		213-20-4307	11	JM 2424 F	75	Yrs.					Jul 8	1929	M	ary1	and
	p ,		Usual Residence of Deceder			100 C	ty, Town or Lo	nation							10d Inside	City Limits
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	it it	Director	10e. Street end Number	1	D 1			10f. Zip		0			10g. Citizen			
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	ite and a	S	11. Maritel Status		Armed Fo		1,5. 13. V	Yes, spec	ify Cuba	in, Mexicar	n, Puerto	ecify Yes or No Rican, etc.)	14.	Black, White	, etc.	,
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Maryland 21215-0020	Shound N		19a. Informant's Name/Rela				19b. Mailin	g Address	(Street	and Numb	er or Rura	I Route Numb	er, City or To	wn, Stete, Z	ip Code)	0
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Baitimore,	보원분 .		21. Signature of Funeral Ser	vice Licens	ee /	10	(22	Name and	d Addres	ss of Facili		ms Fun	0201	Conu	100	D A
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		-	23a. Pert1. Enter the diseas shock, or heart failure.	e, or comp	lications that	caused the dear								1D. Z	Approxir	nate
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_	0 0	Physician	Part II. Other significant con	ditions co	ntributing to d	eath but not res	sulting in the ur	derlying ca	ause giv	en in Part I		23b. Did	obacco ues	contribute		se of death?
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ב	ng P ftar t mare	ü	27. Menner of Deeth 1 Naturel 5 □ Pe	nding	28a. Date (Mon	of Injury th, Dey Year)	28b. Time of Injury		Bc. Injur			28d. Describe I	now injury oc	curred		
Division	endl aeth. or: A	cat	Z LI ACCIDENT	estigation and not be				М		Yes 2□	_	201 1		. 5	10	
$\frac{\ddot{\Xi}}{2}$	r Att	Certification:		termined		e of Injury - At h ing, etc. <i>(Speci</i>		et, factory,	, office		1	28f. Location (S City or Tox	Street and Ni vn, State)	umber or Hu	rai Houte N	lumber,
	urs al	ပီ			1											
	To the Hospital or Attending Physician: white 24 hours after death. Its cartific To the Funeral Director: After this cartific completely filled in by the funeral director.	edical	(Check only 2 Med		ner: On the b	best of my kno asis of examina										e(s)
	thin the	Med	29b. Signature end little of ce	rtifier	anu man	ner stated.		29c	Licens	e number			29d. Date si	gned (Month	Dev. Yea	r)
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	1					MD.	- 00a) (To-		200	5905	6	1	, -/ -	1/04		
	7		30. Name and address of per DALTEET S			se of death (Iter	n∠3a)(Iype,I / / / //	wst	M	+ Ro	161	Arce	B-14	MO	2121	7
	Cu	•0	31. Date filed (Month, Dey, Y			Registrar's Sign				,	, ,	•				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				For State Registrar	State of Ma	aryland / I		nent of He cate of D		Mental Hy	giene Reg. No		21.611
		Physici	an	1. Decedent's Name (First, Middle, L Raymond A. Dy						2. Date of Do		y Year	3. Time of Death
	>	/Medic	al er	4a. Facility Name (If not institution, gi	ive street and number)		4b.	City, Town, or	Location of Dea	th	40	3 2004 County of Death	1
0				Stella Maris @ 5. Social Security Number 6.		e (In yrs. last bii		altimo	ore	2 Data of B		N/A	
1300	E	Funeral Director		217-16-0231	1⊠M 2□F	81		nths Days	Hours Min		1,19	923 Mar	pplace (State or Foreign Intry) y Land
3	2	vland ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	1		-			10d. Inside City Limits
٤_	10	se Mary Ba-f sh Aiffe J	ctor	Md. n/a	3		Balt	imore					N Yes 2 □ No
Je.	<u>5</u>	death with the Maryland rms 23e or 28a-f show rinust be fortified at	l Dire	10e. Street and Number 409 South Ell	lwood Ave	nue	10	of. Zip Code 2122	4		10g. Ci	itizen of What Cou USA	intry?
2		r death	Funeral Director	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was I			Specify Yes or Note of Rican, etc.)	>-	14. Race - Amer Black, White	
1	920	be filed within 72 hours after death with the Marylar tal Hygiene. d other than "natural", or litems 23e or 28a-f show advant. I've Medical Examinat must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🚮 N If Yes, Give Year or Dates:	10		es 2 No	Specify:			Specific	ite
V -	15-0036	within 72 ho nne. Ithan "natur e Medical I	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a	Decedent's	Usual Occupa	ition uring most of wo	orking	16b. K	(ind of Business/li	
7	212	filed within Hygiene. thar than int, the M	omo	Elementary/Secondary (0-12)	College (1-4or 5	+)		Legate			St	tate of	Maryland
()	and		Be	17. Father's Name (First, Middle, Last Julius Dyps)					18. Mother's Na Cathe	me (First, Middle	, _{Maider} Dude		
	Maryland	d 2 should ith and Men 7 is marka traumatic	To	19a. Informant's Name/Relationship	(Type, Print)				nd Number or R	ural Route Numb	er, City	or Town, State, Zi	
		1 and 2 Health am 27 i		Cornell Dypsk: 20a. Method of Disposition	i (brothe					Avenue		Ltimore	, Md21224
	mor	Pages nent of I		1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State		tanis	(Name of y or other place s laus		5,04		Ltimore	
	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Itam 27 is any injury or othar trai		21. Signature of Funeral Service Lice	Six A	<u> </u>	22. Nan	ne and Addres	s of FacilityKa	czorow	ski	Funera	I Home, PA Md 21222
	П	*		23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused y one cause on each lir	the death. Do	_						Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	a consequence	Stire	he	nt	Failur	7		Onset and Death
		Examiner	_	Sequentially list conditions,	b								
		uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence	of):						
	90,	To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	l Exa	resulting in death) Last	Due to (or as	a consequence	of):						
	68760,	ifficate b g physical as the b	edical		d								
	Вох	eath cert attending for use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal death		pic pregnancy				23d. Date of deliv	rery Day Year
	P.O.	that the de ad by the a detached i	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□ Unknown	time of death	5 🗀 Othe	er (specify)					
18		ires tha signad d be det	by	Part II. Other significant conditions	contributing to death but		9	ring cause give	n in Part I.				the cause of death?
	cor	sw require s been si s should b	Completed		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			CNS		24a. Was	an	24b. Were aut	opsy findings available
	al Re	: The law cate has	Com							auto perfe 1 Yes	ormed?	death?	ompletion of cause of 2 No
	Vita	rsician: The s certificate director, pag	o Be	25. Was case referred to medical examiner?	Hospital:	nt 2□ER/O	utpatient 3	DOA Othe	-	ath (Check only		6 ☑Óther (Speci	64
	n of	ding Physician: The h. After this certificate hi tuneral director, page	on: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work	at ?	28d. Describe			" Nospice
	Division of Vital Records,	Attend r death actor: /	Certification;	2 Accident investigati 3 Suicide 6 Could not determine	be 28e. Place of Inju	ury - At home, fa	arm, street, fa		′es 2 □ No	28f. Location (Street ar	nd Number or Rur	al Route Number,
	Ö	urs afte		4 Homicide determine	building, etc					City or To			-
		To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exi	Physician: To the best of aminer: On the basis of and manner sta	examination ar	e, death occi nd/or investig	urred at the time ation, in my op	e, date and place inion, death occ	e, and due to the urred at the time,	date and) and manner as s d place, and due t	stated. o the cause(s)
		To the within To the comp	M	29b. Signature and title of certifier				29c. License	number		29d. Da	ite signed (Month,	
		Κi		30. Name and address of person who	ocompleted cause of d	eath (Item 23a)	(Type, Print)	1040	854			11/1/20	04
		V \	112	David, Risel	nerg 301 5	ST Paul	L.P.I	2 .1.	more.	nol.	212	595	
	*	Sta Regista		31. Date filed (Month, Pay, Year)	104 32 registra	ar's Signature	9 19	parks					

		State of Mary 1 - State engistrer	land / Depa	artment of Hea	alth and M	ental Hygi	-	
Physi		1. Decedent's Name (First, Middle, Last) Mary Lillian Dick				2. Date of Death Month Novemb	n Day Yes	3. Time of Death
/Mec Exam		a me out at the state of the st		4b. City, Town, or Loc	cation of Death		4c. County of D	
	Å	3524 Galloway Road		Bowleys			Baltim	
Funera Directo		5. Social Security Number 216-16-2289 Usual Residence of Decedent 5. Social Security Number 1 □ M 2	yrs. last birthday) Yrs.	If Under 1 Year If I Months Days Ho	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, 2/11/1	9 16 Ri	Birthplace (State or Foreign Country) Chmond, VA
Maryland 9-f show	tor	10a. State 10b. County 10	c. City, Town or Lo Balti					10d. Inside City Limits 1X Yes 2 □ No
h with the 23e or 28	al Director	10e. Street and Number 3403 Noble Street		10f. Zip Code	224		og. Citizen of What USA	Country?
ified within 72 hours after death with the Maryland Hygiene. Hygiene. Instural; or Items 23e or 28e-f show only the Medical Exament must be notified at any.	by Funeral	3 ☑ Widowed 4 □ Divorced Year or Dates:		Was Decedent of Hispar If Yes, specify Cuban, M 1 ☐ Yes 2 🖾 No Sp	inic Origin? (Spe Mexican, Puerto f Pecify:	cify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: W	
ie, ivial ylalla & LELD-O- s 1 and 2 should be filed within 72 ho f Health and Mental Hyglene. Item 27 is marked other than "natur other traumatic event, the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8th College (1-4or 5+)	16a. Dece (Give life. Home	dent's Usual Occupation kind of work done durin DO NOT use retired) maker	n ng most of workir	ng 1	16b. Kind of Busine	,
ally fall of 1.6. 2 should be filed withir and Mental Hyglene. is marked other than aumatic event, the Mental Hyglene.	To Be Co	17. Father's Name (First, Middle, Last) Edward Beck			Rosa	Lee Pa		
and 2 sh lealth and lealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print) daugh Dorothy Rode	3524	Galloway	Rd. B	altimo	re, Md.	21220
permit. Pages 1 and Department of Healt Important: if Item 2 any injury or other	Ì	20a. Method of Disposition 1	Oaklawr	matory or other place) 1	11/4,	/2004 E	20c. Location - City Baltimor	re, MD
permit. Departimonts	-BOUG	21. Signature of Funeral Service Goensee Marea H Banese	2	2. Name and Address of 63 S. Con				o,JR. FH e, MD 21224
Physicia	n	23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only ne cause on each line. Immediate Cause (Final disease or condition	death. Do not ent	ter the mode of dying, su DRCL	uch as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
/Medica Examine	al	resulting in death) Due to (or as Delon	onsequence of):	mp				
ed sit	a du	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury	onsequence of):	. 5 00	by al	do-1	netin ?	0-
be executed ician and burial-transit	Fyaminer	that initiated events resulting in death) Last C. Due to (or as a co	onsequence of):	Jont	- ma	. 010100	show of	tere
ficate be executed physician and is the burial-transit	200	d. Deger	isative	Jont	Dice	are		
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us, r juires that n signed b	by D	Part II. Other significant conditions contributing to death but no	ot resulting in the u	inderlying cause given in	n Part I.			e to the cause of death? Probably 4 Tunknown
	Completed					24a. Was ar autopsy perform 1 Yes 2	prior death	autopsy findings available to completion of cause of 1? res 2 No
VICAT Sician: T s certificat firector, pi	T C	examiner?	2 ER/Outpatier	Other		n (Check only one ne 5 ☐ Reside	/	inecity) DINGITTER
ION OI nding Phy th. : After this s funeral d	tion. T		28b. Time o	of 28c. Injury at Work?			w injury occurred	
DIVISION all or Attending b after death. I Director: Atteid in by the fune	Cartification.	3 Suicide 6 Could not be determined 4 Homicide determined building, etc. (S	- At home, farm, sti Specify)	reet, factory, office	2	28f. Location (Str City or Town		Rural Route Number,
UNISION OI VIKA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.) legipa		amination and/or in					
To th To th comp	B.A.	29b. Signature and title of certifier		29c. License nu D 3(29	Od. Date signed (Me	
h			(Item 23a) (Type,			to 388		mb 21204
	State	Of Bata Stad (Marth Bay Variation) 200 Berickerde		a and a	, , , , ,		- 4	-1-1+
™ Regi	istrai	NOV 0 3 2004 Deneur	er by	April 1				

DHMH 17 Rev 1/2001

		•	1 - For State Registrar	State of M	Maryland / Depa <i>Cei</i>	artment of He tificate of D		ental Hygier Reg. h	2004	34613
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		Eva Eileen Edw	ards			N	lovember 1	2004	1:35P M
4	Examin		4a. Facility Name (If not institution, give	street and number	r)	4b. City, Town, or Lo	ocation of Death	4	c. County of Deatl	
			4905 Oriole Court			Westmins			Carro1	1
	Funeral Director		5. Social Security Number 6. Security Number 215–42–9782	7. A	Age (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	Hours Min	8. Date of Birth (Month, Day, Yea Aug • 13,	Ir) Co	nplace (State or Foreign untry) y Land
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	/anyle	٥	Maryland Carrol	1	Westmir					1 ☐ Yes 2% ☐ No
	28e-i	Director	10e. Street and Number	L	Westilli	10f. Zip Code		10a. (Citizen of What Co	untry?
	With 30 or		4905 Oriole Cou	ırt			1158		U.S.A.	, -
	ma 2:	Funerai		12. Was Deceden	t Ever in U.S. 13.	Vas Decedent of Hisp f Yes, specify Cuban,		offy Yes or No-	14. Race - Amer	
36	be filed within 72 hours after death with the Maryland that Hyglene. ad other than "neturel", or Itema 23e or 28e-f show event, the Mayled Examinational to indiffed a	by Fur	1 ☐ Never Married 2 ☐ Married 3 🏝 Widowed 4 ☐ Divorced	Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates	No		Mexican, Puerto F Specify:	lican, etc.)	Specify: Wh	ite
Maryland 21215-0036	2 hou		15. Decedent's Edu	cation	16a. Dece	lent's Usual Occupation	on	16b.	Kind of Business/l	
215	within 7; ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	e completed) College (1-4o	life I	kind of work done dur DO NOT use retired)	ring most of workin	9		
217	giene. er than	mo.	12			nemaker		(Own Home	
nd	be filed ital Hygie id other event.	Be (17. Father's Name (First, Middle, Last)			11		(First, Middle, Maide	en Sumame)	
yla	2 should be and Menta Is marked reumatic ev	ပို	William Fuller				Laura F			
Nar	2 sh and Is m		19a. Informant's Name/Relationship (Ty			g Address (Street and				
di.	s 1 and 2 should f Health and Men item 27 is marke other treumatic		Ellwood Edwards 20a. Method of Disposition	(Son)	20b. Place of Dispo	riole Cour	-		laryLand Location - City or 1	
Baltimore,	ages or of h		1 ₺ Burial 2 ☐ Cremation 3 ☐ F	Removal from Stat	e cemetery, crer	natory or other place)		A		
語	ritmer ritent ritent njury		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Liceus	201		Park Ceme				
Ba	permit. Pages 1 Department of H Importent: If ite any injury or ott		Demand.	Dely	16	Name and Address tzke Fune 30 Edmond:	son Avenu	ie Catonsv	sville, I ville, MD	nc. 21228
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that ceus ne cause on each	ed the death. Do not ent line.	er the mode of dying,	such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Pnysician		Immediate Cause (Final disease or condition	CA	DIASC	0.				2 Conservation Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):					
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٧7	nsit	Examiner	cause. Enter Underlying	240 10 (01 4	a a consequence on.					
<u> </u>	be executed sicien and burial-transit	Xai	that initiated events resulting in death) Last	Due to (or a	s a consequence of):					
8760,	cate be executed physicien and the burial-transit	dicai		d						
9		ledi				2-25-2 C-431-in-2				
Вох	death certifi e attending d for use as	N/UE	230. Was decedent pregnant	3c. If yes, outcom		Ectopic pregnancy			23d. Date of deliv	*
	0 0	Physician/Me	in the past 12 months? 1 □ Yes 25 No			Other (specify)			Month	Day Year
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Records,	The law requires that the site has been signed by though 2 should be detached.	by	Part II. Other significant conditions con	nthouting to death	but not resulting in the ui	nderlying cause given	in Part I.	1 Yes	use contribute to	the cause of death?
SOL	w requir been si should I	Completed						24a. Was an	24h Were aut	opsy findings available
Re	The lav	mo						autopsy performed?	prior to co	ompletion of cause of
Vital		e C	25. Was case referred to medical				26. Place of Death	(Check only one)	lo 1 Yes	2 No
>	Physicien: this certific ral director,	0 8	eyaminer?	fospital:	tient 2 ER/Outpatien	Other		e 5 X Residence	6 ∏Other (Spec	ifv)
of		i.	27. Manner of Death	28a. Date of In (Month, D	jury 28b. Time of Injury	28c. Injury at Work?	t 2	d. Describe how in		
ior	Attending F r death. ector: After by the funer	atio	1 Natural 5 Pending investigation	(Month)	ay / ca./		s 2 🗆 No			
Division	I or Attend after death Director: ,	Certification:	3 Suicide 6 Could not be determined	28e. Place of li building, e	njury - At home, farm, str etc. (Specify)	eet, factory, office	2	3f. Location (Street a City or Town, Sta		ral Route Number,
	urs af					1				
	To the Hospitel or Atterviewithin 24 hours after de To the Funerel Directo completely filled in by the	Medicai	29a. Certifier (Check only one) Certifying Physical Examination (Check only one)	ner: On the basis and manners	of examination and or his stated.	occurred at the time, restigation, in my opin	, date and place, ar nion, death occurre	nd due to the cause(d at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
	To the To the Comp	Z	29b. Signature and title of certifier			29c. License n	number	29d. D	ate signed (Month	, Day, Year)
				11	(/	13	1949	No	ou, 2nd	2004
	3		30. Name and address of person who co	impleted cause of	death (Iron 23a) (Type,	Print)		λ	1	21157
			Heraulin Bras	lethlur	X2 2 L	errich her	me Su	Se 201	nestra	com men
	Sta Registi	-	NOV 0 3 2004	32. Regis	trar's Gignatule	oorks				

		-	State of Maryland / I	Departm		nd Mental Hyg	_	34614
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last) Marie J. Ecksteil 4a. Facility Name (If not institution, give str Glen Meadows Nul	reet and number)		City, Town, or Location of		Day Year 3, 2004 4c. County of De. Baltimo	10:40 P ^M
Funeral Director			7. Age (In yrs. last bit		nder 1 Year If Under 2 ths Days Hours	8. Date of Birth (Month, Day, March 1	7 1907 M	irthplace (State or Foreign Country) lassachusetts
5-UU3b 72 hours after death with the Maryland "natural", or Itams 23a or 28a-f ehow discal Examiner must be notified at	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10e. Street and Number 11630 Glen Arm R 11. Marital Status 1 □ Never Married 2 □ Married 3 ௸Widowed 4 □ Divorced		en Arı			0g. Citizen of What C USA 14. Race - Arr Black, Wh Specify:	nerican Indian,
Yland 2121 ould be filed within Mental Hygiene. serked other than attic event, the Me	To Be Completed I	15. Decedent's Educa (Specify only highest grade) Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last) Bernard Trainor	ation (16a Completed) College (1-4or 5+)	(Give kind of life. DO No.	18. Mother	of working 's Name (First, Middle, I	Maiden Surname)	n Home
Baltimore, Mar's permit. Pages 1 and 2 shd Department of Health and Important: If item 27 la many injury or other traum.		John P. Eckstein/S 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Fig.	moval from State Dula	115 Hi of Disposition ory, crematory nney V 22. Nam Len	ghland Ridg (Name of or other place) alley Memor e and Address of Facility mon Funera W. Padonia	10/27/04 ial Gardens al Home of I Rd. Timor	enix, MD 200. Location - City o Timonium Dulaney V	21131 or Town, State n, MD Valley, Inc.
are be executed Wedical Wasician and he burial-transit	cal Examiner	23a Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence	o of): o of): VW	Hode of dying, such as to			Interval Between Opset and Death Weeth Weeth
O. Box 687 he death certificate the attending phy.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes ≥ 15 No 9 □ Unknown	c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		oic pregnancy or (specify)		23d. Date of d Month	elivery Day Year
Records, P. The law requires that the has been signed by the grape?	Completed by	Part II. Other significant conditions cont Demunua Atau Junua		in the underly	ing cause given in Part I.	1 ☐ Ye	n 24b. Were a prior to death?	to the cause of death? Probably 4 Unknown autopsy findings available occmpletion of cause of
Division of Vital Re To the Hospital or Attanding Physician: The la within 24 hours after death. To tha Funaral Diractor: Alfer this certificate has completely filled in by the funeral director, page 2	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Many r of Death 1 Natural 5 Pending 2 Accident investigation		Putpatient 3[Time of Injury	DOA Other: 4 July 28c. Injury at Work?			ecify)
Division of To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	al Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, f building, etc. (Specify) cian: To the best of my knowledg			City or Town		
To the Hos within 24 hor To the Fun	Medical	(Check only 2 Medical Examin one) 29b. Signature and title of certifier	er: On the basis of examination as and manner stated.	nd/or investig	29c. License number	h occurred at the time, d	ate and place, and du	ue to the cause(s)
0	tate	30. Name and address of person who core M M M M M M M M M M M M M M M M M M M	32. Registrar's Signature	(Type, Print)	CHARLES	57 154	LTIMDRE	MD 2124
Regis		NOV 0 3 20	304 Deneva	9	Sporter			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 0014 34615 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** 2004 November 2, 2:20 AM William Herbert Flamm Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore 8. Date of Birth Month, Day, Feb 16, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1959 **№** M 2□ F 45 Yrs. 213-76-2322 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2X No Directo Maryland Dunda1k 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1949 Sunberry Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X ☐ No Specify: Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Welder 12 Construction 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 Is marked oth any injury or other traumatic event spice. 17. Father's Name (First, Middle, Last) Be William Herbert Flamm Sr. Patricia Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2711 Aston Avenue Plant City, Florida 33566 William Herbert Flamm Sr. Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Stremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/03/04 Baltimore, Maryland 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Ricensee Thomas Gregor O 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) milyre **Physician** /Medical Due to (or as a consequence of): Examiner hepatitis Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a c Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Tes 21 No or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funaral Diract completely filled in by 4 Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) ype, Print) m Hospice 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

アノイタグ

		1	For State Registrar		State of Ma	aryland	Cer	rtment of H tificate of l	ieaith ai D <i>eath</i>	nd Mental Hy	Reg. No.	104	34616
			1. Decedent's Name	(First, Middle, Last)					2. Date of D Month	eath Day	Year	3. Time of Death
	Physicia	-	Edna M	lae Fultz						Octobe		2004	05:10 A M
y	/Medic Examin		la. Facility Name (If	not institution, give	street and number)			4b. City, Town, or	Location of	Death	4c. Cou	inty of Deat	h
	LAGIIIII		Milleni	um at Mar	levneck			Glen Bu	rnie		An	ne Arı	ındel
	Funeral		5. Social Security N			e (In yrs. las	st birthday)	If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Date of B	irth	9. Birt	hplace (State or Foreign
	Director		213.30.83	114	^{3 M 2} G F	1	Yrs.	World's Days	Flours	01-17-			to, Md
	ъ		Usual Residence of	Decedent		10.00							10d. Inside City Limits
	how	.	10a. State	10b. County			Town or Loc						1 Tes 2 No
	e Ma	cţo	Md	Anne Arun	del	Pa	sadena						
	or 28	Director	10e. Street and Nur	nber				10f. Zip Code			10g. Citizen	of What Co	ountry?
	23e		230 Oak	Hollow Ct				21122			USA		
	ems er u	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S	. 13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origi an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)		Hace - Ame Black, Whit	encan Indian, e, etc.
9	or It		_	ed 2 Married	1 ∐ Yes 2 🛣 If Yes, Give	No	1	☐ Yes 2 No	Specify:		Spi	ecify: wh	ite
ဗ္ဗ	urel',	q p	3. Widowed		Year or Dates:	1		ent's Usual Occup	ation		16h Kind o	of Business	
5	"net	lete	(Spec	15. Decedent's Edition only highest grad	de completed)		(Give	kind of work done	during most	of working	Tob. rand c	51 Duoi1100u	
12	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show the Marilest Estaniter must be nutilised.	Completed by	Elementary/Seco	ndary (0-12)	College (1-4or 5		Schoo!	L Bus Dri	ver		Tran	sporta	ation
22	e filed within al Hygiene. I other then "		17. Father's Name	(First, Middle, Last)					18. Mother	's Name (First, Midd			
an	d be	o Be			ıla				Bord	tha Leona			
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Item 27 Is marked other then "neturel", or Items 23e or 28e-f show item 27 Is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, I're Maryles Extending man mast be natified at	2		Villis Fis ame/Relationship (7			19b. Mailin	g Address (Street		or Rural Route Num	ber, City or To	wn, State,	Zip Code)
S	id 2 s ith ar 27 is treu			Crouse- Da			230 Oa	ak Hollow	v Ct.	Pasadena,	Md 211	22	
a)	os 1 and 2 of Health of item 27 li		20a. Method of Dis	position				sition (Name of natory or other place		Date			Town, State
no	Pages nent of nnt: If it ury or o		1 Burial 2	Cremation 3 5 Other (Specify	Removal from State			Washingt	ı	1/2/04	Laur	el, M	đ
Baltimore,				ineral Service Licen		Dur	22	. Name and Addre					Hm.atMMP INC
Ba	permit. Departr Importe any inju		MYK	CY. Ha	Jamo-					Blvđ. Elkr			
			23a. Part1. Enter	he disease, or comp	olications that caused	d the death.	Do not ent	er the mode of dyin	ng, such as o	cardiac or respiratory	arrest,		Approximate Interval Between
			Immediate Cause	(Final	one cause on each li	CA	RI	1410	INI	FARCT	TONI		Onset and Death
	Fnysician /Medical		disease or condition resulting in death)		a. Due to lor as	a consequ	ence of):	1110					
	Examiner				ESSE	EN	TIA	L HY	PER	TEN!	Bion	1	12 YEARS
		ē	Sequentially list co if any, leading to ir cause. Enter Undo Cause (Disease or	onditions, nmediate	Due to (or as	a consequ	ence of):			11.6			104500
	be executed sician and burial-transit	Examiner	Cause (Disease or	injury s	· DIA	13F	TES	ME	LLIT	LN7			17 154KZ
oʻ	exec an ar rial-tr	Ex	resulting in death)	Last	Due to (or as	a consequ	ence of):						
8760,	cate be executed physician and the burial-transit	dlcal			d								
9	tifica ng ph as th	led	IF FEMALE:										
Box	death certifica attending pt d for use as t	an/h	23b. Was deceder		23c. If yes, outcome 1 ☐ Live birth		death 3[Ectopic pregnanc	:у		23d	 Date of de Month 	livery Day Year
	ne deal the att hed fo	Physiclan/Me	in the past 12	No	4☐Pregnant a 9☐ Unknown	t time of de	ath 5	Other (specify) _					,
P.0	that the de ed by the detached	Phy	9 🗆 Unknowi		ontributing to death t		lainer in the co	adoshina sausa an	von in Bart I	23e Di	t tobacco use	contribute t	o the cause of death?
	es De g	by	Part II. Other sign	P A I	ontributing to death t) R		C C C C C C C C C C C C C C C C C C C	venin ranti.		Yes 2		robably 4 Unknown
brd	w requir been si should	ted	2110	1770	DECI	, , , ,	,) V =	7					
Records,	as be	Completed	ALC	-HEIN	1ERS	DC-	SEA	7 F		24a. W	as an topsy formed?	4b. Were a prior to death?	utopsy findings available completion of cause of
R		Con						_		1 ☐ Yes			s 2 No
Vital	Physicien: The law this certificate has t ral director, page 2 s	Be (25. Was case refe examiner?	rred to medical				0		o Death Check on			
of V	> .º 0	2	1 ☐ Yes 2 1	No		1	ER/Outpatie	nt 3 DOA	and the second second	rsing Home 5 Re	sidence 6 [ecify)
		on:	27. Minns of Dea	5 Pending	28a. Date of Inj (Month, Da	ay Year)	28b. Time o Injury	Wo	ork?]Yes 2∐!		e now injury o	Comed	
Sio	Attending r death. Sctor: Afte oy the fune	catl	2 Accident 3 Suicide	investigation 6 Could not b		iun. At ho	mo farm et	reet, factory, office			(Street and N	Jumber or F	Rural Route Number,
Division	or At fter d Direct in by	Certification;	4 Homicide	dataminad	ZOU. FIACE OF III	itc. (Specify	')	leet, ractory, onice	•		Town, State)		
	Hospitel or 24 hours afte Funerel Dir tely filled in		29a. Certifier	18 Certifying Ph	nysicien: To the best	t of my kno	wiedge, deat	th occurred at the t	ime, date an	d place, and due to the	ne cause(s) ar	nd manner a	as stated.
	To the Hospitel or Attent within 24 hours after death To the Eunerel Director: completely filled in by the	Medical	(Check only one)	2 Medicel Exer	niner: On the basis of and manner s	of examinal	ion and/or in	vestigation, in my	opinion, dea	th occurred at the tim	e, date and pi	ace, and du	e to the cause(s)
	within 2 To the comple	Me	29b. Signatura an	d title of certifier	al			29c. Licen	ise number	Co.	29d. Date s		oth, Day, Year)
			1 2	100000	-1	Wi	Z	17	171	(000)	CIOE	ER:	2007
	\		30. pape Ange	drees of person To	completed tailse of	death (Item	23 2) ((ype	(POT A R MAG	ITCH ZYLA	IE HIGH	WAY 1225	BA	LTIMORE
		ate	31. Date filed (Mo	onth, Day, Year) V 0 3 2004	4.5	trar's Signa	ture		(
	Regist												

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydierec of

			For State Registrer	State of Ma	aryland / De	epartment of i Sertificate of	neaith a Death	and Me		e2e0 0 4	34617
	Physici	an	1. Decedent's Name (First, Middle, Las	it)					Date of Death	Day Yea	3. Time of Death
	/Medic		Elizabeth Ann			T			CIOBER	29 20	04 11:15 M
	Examin	er	4a. Facility Name (If not institution, give	OSPITAL		4b. City, Town,		of Death NOR	-	4c. County of De	eath .
	Funeral		5. Social Security Number 6. S		e (In yrs. last birtho	ay) If Under 1 Year	If Under	24 Hrs. 8.	Date of Birth	9. E	Birthplace (State or Foreign Country)
	Director		210-20-3007	□M 21⊠F	73 Yr	Months Days	Hours	Min. M	(Month, Day, lay 8,	1931 Ma	ryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	r Location					10d. Inside City Limits
	d sho	lor	Maryland Baltim	ore	Caton	sville					1 ☐ Yes 2X No
	r 28a	rec	10e. Street and Number	516	Caton	10f. Zip Code			10	g. Citizen of What	Country?
	th with	Funeral Director	717 Maiden Choice	e Lane #32	5	212	28			U.S.A.	
	r dea	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cub	Hispanic Ori an, Mexicar	igin? (Specif n, Puerto Ric	y Yes or No- an, etc.)	14. Race - Ar Black, W	nerican Indian, hite, etc.
36	be filed within 72 hours after death with the Maryland hal Hygiene. diother than "natural", or Itame 23e or 28e-f show event, the Medical Exam har must be notified at	by Fi	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X N If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ₺ No	Specify:	:		Specify:	White
Maryland 21215-0036	2 hou	ted t	15. Decedent's Ed	lucation	16a. D	ecedent's Usual Occu	pation		1	6b. Kind of Busines	
215	thin 7. e. an "n	Completed	(Specify only highest gra	College (1-4or 5	i+) ((live kind of work done fe. DO NOT use retire	during mos id)	st of working			
7	ygien ygien ner th		12		Во	okkeeper					Stationers
and	ntai H ed oti	Be	17. Father's Name (First, Middle, Last) William Lawrence						erine l	faiden Sumame)	
2	should ad Me mark matic	ဥ	19a. Informant's Name/Relationship (19b. N	ailing Address (Stree					. Zip Code)
Z	is 1 and 2 and 1 to the site of Health are itam 27 is other trau		James E. Freeman								, MD 21228
ore,	es 1 a of Hea fitam r othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Domaval from State	20h Place of D	sposition /Name of	1	Date		0c. Location - City	
Ĕ	Page ment ant: if ury o	١,	'4 □ Donation 5 □ Other (Specify		Memoria	crematory or other pla Valley L Gardens		11-3-2		imonium,	Maryland
Baltimore,	permit. Pages 1 and 2 should be illed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23e or 28e-f show any injury or other traumatic evant, the Medical Establish must be notified at Once.		21. Signature of Funeral Service Licen	see		22 Name and Addre Witzke Fu	ess of Facilit neral	^{ty} Home	of Cato	onsville,	Inc.
	00260		23a Part 1 Enter the disease or com-	plications that caused	the death. Do no	HOHIDA OCOL	uson F	ave. c	atonsv:	ıııe, mar	yland 21228 Approximate
			23a. Part1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final								Interval Between Onset and Death
	Pnysician /Medical	ľ	disease or condition resulting in death)		a consequence of)	NIAL H	MUK	LHHA	1 E		5 Hours
	Examiner		Output all list and dising			STOPEN	IA				6 MONTHS
	р ц	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		a consequence of)						1 1100000
111	and and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequence of)	ANEN	114				6 M antits
68760,	be ex			200 10 (01 40	a sansoquenes on						
687	tificate be executed g physician and as the burial-transit	edical		d							
Вох		an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 Ectopic pregnanc	v			23d. Date of c	,
O.	The law requires that the death certate has been signed by the attendinoage 2 should be detached for use	Physician/N	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4∏Pregnant at 9∏Unknown	time of death	5 Other (specify)				Month	Day Year
О.	that the	/ Ph	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the	e underlying cause gr	ven in Part I.		23e. Did tob.	acco use contribute	to the cause of death?
gp.	uires n sign	d by							1 🗌 Yes	s 2 No 3 🗆	Probably 4 Unknown
000	s been si s should I	olete							24a. Was an		autopsy findings available
Vital Records,	The lav	Completed							autopsy perform	ed? death'	o completion of cause of es 2 No
ital	ysician: This sertificate director, pag	Be C	25. Was case referred to medical examiner?					of Death (C	Check only one		
of V	d is	၉	1 Yes 2 No	Hospital: 1 Inpatie		Ment 30 DOA				nce 6 Other (Sp	pecify)
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Division	500>	fica	3 Suicide 6 Could not be	e 28e. Place of Inju	ury - At home, farm	, street, factory, office					Rural Route Number,
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	thin 2 thin 2 tha omphal	Med	29b. Signature and title of certifier	and manner sta	ited.	29c. Licen				d. Date signed (Mo	
)	F 3 F ŏ		> attaur	20		Pil	693	5	0	TOBER	,29,2004
	1		30. Name and address of person who	completed cause of d	eath (Item 23a) (Ty	pe, Print) HOSP (7	. ^	901) CATO	N AVE	WE
	5		DR. M. SARUM		AGNH	HOSPIT	M	Be	ALTIM	ORE, MC	21229-
	Sta Registi		31. Date filed (Month, Day, Year) 7 2004	32. Registra	ar's Signature	Sporks	,				

r Items 23a	Director	4a. Facility Name (If not institution, Gilchrist Cent 5. Social Security Number 283-42-4785 Usual Residence of Decedent 10a. State 10b. County Maryland Ba 10e. Street and Number	er 5. Sex 1 □ M 2 ☑ F	In yrs. last birthday, 90 Yrs. 0c. City, Town or L	Т	OWSON If Under 24 Hrs.	November	Day Year 1 2004 4c. County of De	7:55 P
ir safter death with the Maryland ii, or items 23e or 28e-f show commerce must be rediffed at	Director	Gilchrist Cent 5. Social Security Number 283-42-4785 Usual Residence of Decedent 10a. State 10b. County Maryland Ba 10e. Street and Number	ET. 5. Sex 1 □ M 2 ☑ F 7. Age (i	90 Yrs.	T If Under 1 Year	OWSON If Under 24 Hrs.		4c. County of De	ath
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or items 23	Director	10a. State 10b. County Maryland Ba 10e. Street and Number		0c. City, Town or L		Hours Min.	(Month, Day, Y July 29.	1914 9. G	rthplace (State or Fore Country) 0hi0
or items 23		10e. Street and Number	ltimore		ocation				10d. Inside City Lim
or items 23		10e. Street and Number	ucumone		Baltimo	a tro			1 ☐ Yes 2 🔀
or items 23					10f. Zip Code	ne	10g	g. Citizen of What C	Country?
IIS 8	nue	4220 Garland A	lvenue		212	236		U. S. 1	4.
In 72 hours "nature tedlical E	Dy F	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 _ Yes 2 V No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
10 P		15. Decedent's	Education		edent's Usual Occup		16	6b. Kind of Busines	White s/Industry
Far S	mple	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-4or 5+)	life.	DO NOT use retired	,		Ohio	
	3	12th Grade 17. Father's Name (First, Middle, L.	ast)		<u>Bookkeepe</u>	た 18. Mother's Name		County Of	fice
	o Re	William Miner					e Brown		
d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationshi		19b. Maili	ing Address (Street	and Number or Rura		City or Town, State,	Zip Code)
s 1 and 3 temps of Health item 27 other tr	-		(Daughter)	422	0 Garland	Ave., Ba	ctimore,	Maryland	21236
9 = 2		20a. Method of Disposition 1 ☐ Burial 2 🂢 Cremation :	3 □Removal from State	cemetery, cre	matory or other plac	(8)			,
nit. Pa lartmen ortant: injury injury	Ē	* 4 □ Donation 5 □ Other (Special Service L.1 Signature of Funeral Service L.1		Bayview (Crematory	11/4/2	2004 Bo	ultimore.	Maryland
permit. Departn Importa eny injk		Q Contable	- Alaka	9	705 Belai	ss of Facility Sch r Rd., Ba	ımunek tı ltimore,	ineral Ho Maryland	mes 21236
be be	al Exa	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause inter Underlying Cause interest of the introduced events resulting in death) Last	a. Due to (or as a c b. Due to (or as a c c. Due to (or as a c	onsequence of):	canc	eR			Interval Between Onset and Death MMMH
cate chys			d						
that the death certifica ed by the attending ph detached for use as the physician/Med	ysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 [4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	elivery Day Year
es the igner	5	Part II. Other significant condition	s contributing to death but n	not resulting in the u	underlying cause give	en in Part I.	23e. Did tobad	_	o the cause of death?
The law ate has b page 2 sl	_ ر						24a. Was an autopsy performe 1 ☐ Yes 2	prior to	utopsy findings availal completion of cause of s 2 \sum No
		25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Othe	26. Place of Death	-		Transia.
fter fter	ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date of Injury (Month, Day Yo	CONTRACTOR OF THE PROPERTY OF	of 28c. Injury	4 Nursing non	8d. Describe how	e 6 XOther (Speinjury occurred	ecity) Hospic
tal or Attending P rs after death. el Director: Attent led in by the funera	Certilic	3 Suicide 6 Could no 4 Homicide determin		- At home, farm, str Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
he Hospi in 24 hou he Funer pletely fill	ealcai	29a. Certifier (Check only one) 1 Certifying 2 Medicel Ex	Physicien: To the best of n xaminer: On the basis of ex and manner stated	amination and/or in	th occurred at the time	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and du	s stated. e to the cause(s)
with void to	2	29b. Signature and title of certifier	long Ril	ez. und	29c. License	5205	N		th, Day, Year)
12		30. Name and address of person w	ho completed cause of deal	(Item 23a) (Type,	Print) 66 To	001 N. Cha owson, MD	rles Str 21204	eet	
State Registrar	1	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	1				

ORIGINAL

FISSELL, Lucy

State of Maryland / Department of Health and Mental Hygiepen 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month **Physician** OCTOBOR 08:05 M Norman E. Fields 2004 30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 1. AGNES HOSP ITAL If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y 09-29-1934 Birthplace (State or Foreign Country) **Funeral** Months Days Min. 12 M 2□ F Hours Yrs. 72 Director 219-28-3312 Maryland Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits er then "natural", or items 23s or 28e-f show the Medical Examiner must be nutified at 1 X Yes 2 □ No Director MD NA **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 Appleton St. 21216 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 DaYes 2 □ No If Yes, Give 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed with Health and Mental Hygiene. Custodian Maintainance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Wooden Robert Henry Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Pages 1 and a ... ritment of Health ar ortent; if item 27 le Ruth Chandler/Cousin 1607 Deepcreek Blvd. Apt E. Portsmouth, VA 23704 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Importent: If any injury or once. Baltimore, MD Baltimore National Cemetery 11-08-2004 21. Signature of Funeral Service Lie 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor St. Balto, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MASSIVE Immediate Cause (Final CEREBROVASCULAR Pnysician 3 DAYS disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence ora Examiner physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of deliver 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Nnknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy performed? (es 2) No certificate 1 Yes Division of Vital Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation Natural death. 2 No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the 29b. Signature and tiffa of certifier 29c. License number 29d. Date signed (Month, Day, Year) DR. P16693 DCTOBER 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARUMI HOSPITAL 51 -AGNU 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygien 2004 34620 For State Registrar 1-Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 430A M 31,2004 ctobe. Lavere /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner York Marcheste 339 ti Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month. Den Year 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign Mary Land **Funeral** Months -14-5135 X2 M 2□ F Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show event, the Medical Examiner must be notified at 1∏Yes 2□No Md. Carroll Manchester Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3396 York St. or iteme 23a 21102 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item in yor other traumatic event, the Medical Examinat once. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 ∰ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) 12 Driver Examiner Motor Vehicle Adm. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Maurice Fowble Erma Rachel Shaffer 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3396 York St., Manchester, Md. 21102 Mildred L. Melton -Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1) Burial 2 Cremation 3 Removal from State Millers Church Cem. 4 ☐ Donation 5 ☐ Other (Specify) Nov. 3, 2004 Millers, Md. 22. Name and Address of Facility
Eckhardt Funeral Chapel, P.A. 21. Signature of Funeral Service Licenses 23a. Pert Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op dach line. 21102 Manchester, Approximate tnterval Between Onset and De th Immediate Cause (Final ere brovasc Priysician disease or condition /Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Certification: To Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy ō in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. pe 3 Probably 4 Unknown 1 Tes 2 100 in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 20 No 2 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient Other: 4 Nursing Home Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28d. escribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kus Stoner Nestminstel Willer 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

			For State Registrar	State of Maryla	nd / Depa	artment of H	lealth ai Death	nd Me		gien e) (104	34621
	Physicia	an	1. Decedent's Name (First, Middle, L.	1	edly				Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Beatrice		Carro				cione		2004	7:25 AM
	Examin	er	4a. Facility Name (If not institution, gi		tome	4b. City, Town, or					ty of Death	re count
	Funeral		Social Security Number 6.	Sex 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 2		. Date of Birtl (Month, Day			place (State or Foreign
	Director		236-34-6369	1□M 2\\ F	91 Yrs.	Months Days	Hours	Min.	$\underset{ug}{Month}, Da_{y}$	1913	West	Virginia
	pur 3	}	Usual Residence of Decedent 10a. State 10b. County	100 (City, Town or Lo	neation						0d. Inside City Limits
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	ith the Marylan or 28a-f ahow	rect	10e. Street and Number			10f. Zip Code				10g. Citizen o	of What Cour	
	h with	Funeral Director	4511 Robosson Ro	ad		2	21133				USA	
	ems :	iner	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H I Yes, specify Cuba	ispanic Origi	in? (Specif	y Yes or No-	14. R	ace - Americ	
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2	s i end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic avent. Its Medical Examinational be notified at	Be	17. Father's Name (First, Middle, Las							Maiden Sum		
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Ď	1 end Healt em 2		Chapel Hill Nurs		. Place of Dispo	Robosson	Road	Rand Dat		wn, MD 20c. Location		
5	permit. Pages 1 end 2 Department of Health a Important: If item 27 is any injury or other trat		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☑ Donation 5 ☐ Other (Spec	☐Removal Irom State	cemetery, crei	natory or other place	e)			Edd. Eddation	ii ony oi re	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	nit. Partme ortan injur.		21. Signature of Funeral Service Lice Ronal d S		22	2. Name and Addres	ss of Facility					
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	3		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused the de	ath. Do not ent	er the mode of dyin	g, such as ca	ardiac or r	espiratory arr	rest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		rial I	neumo	nia					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	equence of):							
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5	he dea the al	/sici	1 Yes 2 No	4□Pregnant at time of 9□ Unknown	death 5	Other (specify)					Month	Day Year
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ב	fhe la te has age 2	Completed							autop: perfor	sy med?	prior to cor death?	impletion of cause of
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			30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)		000	20:	-) =		13 2 1 21
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			For State	State of	Maryland /	Depa Cen	rtment of H	lealth and N			34622
			1 - State RegistrarAMEND TTE 1. Decedent's Name (First, Middle	M #5 PER F	4H_G837_1	1705	OF JH	Jean	2. Date of Deat		3. Time of Death
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	Funeral Director		5. Social Security Number 213 - 01 - 34667	6. Sex 1 M 2 □ F	91	Yrs.	Months Days	Hours Min.	Feb. 0	4,1913 M	ountry) aryland
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	show	<u>_</u>	10a. State 10b. County		10c. City, To	own or Loc	ation				10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	3a or	<u>a</u>	1624 Jackson St	reet				1230		U.S.A.	•
	death	Funeral	11. Marital Status		ent Ever in U.S.	13. W		ispanic Origin? (San, Mexican, Puerto	pecify Yes or No-	14. Race - Ame Black, Whit	
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DIVISION	ttand death ctor: /	icat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	not be and Bloom	of Injury - At home	, tarm, stre		195 2 110	28t. Location (Si	treet and Number or R	ural Route Number,
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	To viti	-	29b. Signature and title of certifie				115	1 6 0		Date signed (MON	, Day, 1841)
			30. Name and address of person	who completed cause	of death (Item 23	a) (Type I	Print)	6 70		7/61/	V Y
	8		MALC S	10 In	FI	w	114	175.	Howo	UER ST	,
	Sta		31. Date tiled (Month, Day, Year)	2004 32. Re	gistrar's Signature	4	1	A .			
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DHMH 17 Rev 1/2001

30-08

State of Maryland / Department of Health and Mental Hygiene) 34623 1- State Registramend ITEM #19a PER FH G837 1965/04 of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 1:15 PM **Physician** JRACE 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KITC HOSPICE TIMORE HIE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Davs | Hours | Min. (Month, Day) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Months Days 1 □ M 2 🔀 F 216-32-7986 NORTH (Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic event, the Medical Examiner must be nutified at 1 Yes 2 □ No Directo MARYLAND 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 AVENUE USA or Itams 23a Funerai death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: BLACK þ 3 X Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 and Mental Hygiene.
7 is markad othar than "r College (1-4or 5+) Elementary/Secondary (0-12) SEAMSTRESS LOTHING UNKNO WIN) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be DOUGLAS ADAMS WILL Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 202 E MONTCASTLE DR. GREENSBORD N. C.27406 SONI 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State = 5 GARRISONFOREST 11-05-04 OWINGS MILLS 4 ☐ Donation 5 ☐ Other (Specify) injury 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

23. Name and Address of Facility

24. Name and Address of Facility

25. Name and Address of Facility

26. Name and Address of Facility

27. Funeral Ral Home Ral Home

28. Name and Address of Facility

29. Name and Address of Facility JR, FUNERAL HOME Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) nonsmall cell **Physician** Stage IV Lung cancer 8 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) _ P.O. | 9☐ Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2□No To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 ☐ Yes 2 XNo 은 5 ☐ Residence 6 NOther (Specify) HOS (1) (S. this Diractor: After this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 **Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51788 10/30/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air MD ZIO14 MP 620 Boulton St. 31, Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 03 2004 DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001. 34624 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Roland Junior Gover November 1913 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/AGood Samaritan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Mar. 18, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Min. Hours **™** M 2□F 82 214-16-9559 1922 Mar. Director Maryland Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28a-f show other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Directo Maryland N/ABaltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 4101 Southern Avenue 21206 USA or Items 23e Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 1941 If Yes, Give Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Specify: Specify: White ģ 3 Widowed 4 Divorced 'naturel', Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Master Carpenter Baltimore City permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked othe any injury or other treumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ford Fred Gover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret A. Gover / Wife 4101 Southern Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 11/03/04 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee
Thomas Gregor 22. Name and Address of Facility Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tenosis **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed as the burial-transit Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 2 No 2 No 1 Yes Division of Vital if or Attending Physicien: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ٩ 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 T Homicide To the Hospitel within 24 hours a To the Funerel (1 🔀 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Morth, Day, Year) 29b. Signatuş 25733 30. Name and address of gerson, who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Blud Baltimore, MD 21239 Salmon MD 32. Registrar's Signature 31. Date filed (Mo State Registra

			1- For Amend Item 20b There of Mac dand 1 Department of Health a Certificate of Death		•	ື່ອດດເ	34625
			Decedent's Name (First, Middle, Last)		ite of Death		3. Time of Death
	Physici /Medi		Nellie Lee Gallagher		to ber	30,2004	9:50 PM
	Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of		1	c. County of Death	
			Charlestown Catons	ville		Baltin	1010
	Funeral	11/4	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2		te of Birth	9 Righ	place (State or Foreign
2	Director		218-22-0229 90 Yrs.	Jun	e 3, 19	14 Mary	land
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	Manyl feho	ō					1 ☐ Yes 2½ No
	28a	ec	Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code		100 C	itizen of What Cou	
	3a or	ā	101 0 0 0 0 0				ridy?
	death	Funeral Director		in? (Specify Ye		U.S.A.	can Indian.
9	after or its	F	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican,	, Puerto Rican,	etc.)	Black, White,	
8	72 hours after death with the Maryland natural, or itema 23a or 28a-1 show disal Exantiner must be routified at	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:			Specify: Whi	te
5	72 h netu	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of	of working	16b. I	Kind of Business/In	dustry
12	vithin ne. hen	mpi	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of life. DO NOT use retired)	•			
20	be filed within 72 hours after death with the Marylan stal Hyglene. Id other then "natural", or itama 23s or 28s-1 show event, the Medical Examiner must be notified at		12 Clerical 17. Father's Name (First, Middle, Last) 18. Mother:	4- N (5)		Social So	ecurity
and	od of	Be		r's Name (First,		n Sumame)	
Ξ	should be ind Menta imerked umetic ev	오		len Ker			
Maryland 21215-0036	C) a m m						
	Health Health tom 27		20a Method of Disposition 20h Place of Disposition (Mana of	Data		.aryLand 2 Location - City or To	
100	Pages nent of int; if it		1 Burial 2 To Cremation 3 Removal from State 1 Donation 5 Other (Specify) 1 Donation 5 Other (Specify)) /OV.			
Baltimore,	artme ortan injur		21. Signature of Funeral Service Licensee			rel, Maryla	
Ba	permit. Departi		MOOS69 Witzke Funeral H 1630 Edmondson A	lome of	Catons	ville, Ir	ic.
45	d d		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dving such as ca	ardiac or respir	atory arrest.	ille, Mar	Tyland 21228 Approximate
	Physician		Immediate Cause (Final		,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):				
	Examiner						
7		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):				
11	ecute ind trans	Examiner	that initiated events c.				
760,	be executed sicien and burial-transit		Due to (or as a consequence of):				
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9 x 0	leath certific attending p	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy				
Bo	atten for u	cian	in the past 12 months?		1	23d. Date of delive Month	ry Day Year
o.	y the	ysi	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				
٠ <u>,</u>	res that the de igned by the a be detached f	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	236	e. Did tobacco	use contribute to th	e cause of death?
Records,	law requires that the as been signed by th 2 should be detache				1 ☐ Yes 2	□No 3 □ Prob	ably 4 Dunknown
ပ္ပ	s bee	Completed		248	a. Was an	24b. Were autor	osy findings available
	0 - 2	mo		_	autopsy performed?	prior to con death?	npletion of cause of
Vital	vician: Th certificate rector, pag	0	25. Was case referred to medical 26. Place of	of Death (Check	Yes 2 No	1 □ Yes	2 ∐ No
	0 0 D	To B	Ha spital:			6 ☐Other (Specify	
n of	ding Ph h. After thi funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 1 Sec. Injury at 1 ☐ Natural 5 ☐ Pending (Month, Day Year) Injury Work?	4 / 50 / 4	scribe how injus		/
20	Attending ir death. ector: After by the fune	catio	2 Accident investigation M 1 Yes 2 No	0			
Division	2 9 5 6	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Loca City	ation (Street and	nd Number or Rurai	Route Number,
	urs a						
	To the Hospitel of within 24 hours aft To the Funerel Discompletely filled in	edicai	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death of any one)	place, and due occurred at the	to the cause(s) time, date and	and manner as stand place, and due to	ated. the cause(s)
	ithin (Mec	one) and manner stated. 29b. Signature and title of certifier 29c. License number		-		
	F 3 F 8		My stone MD DUTE	30		te signed (Month, L	
			29 Name and address of pelson who completed cause of leath (Item 23a) (Type, Print)		100	ober s	1,2004
	12		Phillip Stone, 711 Maiden Choice L	ch e	Balti	M 919W	1,2004 D21228
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			11010	レヘムム
s,ē	Registra	ar	NOV 0 3 2004 beneva & spacks				

DHMH 17 Rev 1/2001

		For State Registrar	State	of Maryland / I	Depa <i>Cei</i>	artment of H	lealth a Death	nd Mental H	ygiene Reg. No	2004	34626
Physic	an	1. Decedent's Name (First, Midd						2. Date of E Month	Death Da	y Year	3. Time of Death
/Media	al	Sister Jul 4a. Facility Name (If not institution				4b. City, Town, or	I ocation of	Octobe		9 2004 County of Deat	
Examin	er	Bon Secours Pr		·		Marriot			40	Howard	,,,
Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 💢 F	7. Age (In yrs. last bit		If Under 1 Year Months Days	If Under 2	4 Hrs. 8 Date of B	Birth Day, Year)	0.0:4	hplace (State or Foreign untry)
Director		202-07-0863 Usual Residence of Decedent	1LJM 2JAJF	84	Yrs.	- Jays	110010	Min. April 7	, 1920	PÃ	•
land ow		10a. State 10b. Count	y	10c. City, Tow	vn or Lo	cation					10d. Inside City Limits
Man Hisd	tor	Maryland Howard	1	Marri	otts	ville					1 ☐ Yes 2 ☐ No
ith the	Jirec	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
death with the Maryland ms 23e or 28e-f show rmust be notified at	rail	1525 Marriottsvil				21104				ed States	
ē 2 2	Funerai Director	11. Marital Status 1 Never Married 2 Ma	rried Armed F	2 Y No			ispanic Origi n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame Black, White	e, etc.
Maryland 21215-0036 of 2 should be filed within 72 hours after than Mental Hygiene. 27 is marked other than "natural; or the traumatic event, the Medical Equipment	by	3 Widowed 4 Divorce	If Vac G	ive		I□Yes 2∏ No	Specify:			Specify: Whi	te
15-C	Completed	(Specify only high	nt's Education est grade completed) 16a	(Give	tent's Usual Occupa kind of work done o OO NOT use retired	during most of	of working	16b. K	ind of Business/	Industry
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be filed at Hyg other	Be C	17. Father's Name (First, Middle	, Last)	100	CRIS	Let et nut se	18. Mother	s Name (First, Middl			
Maryland 2121: 12 should be filed within In and Mantal Hygienal Hygiens I is marked other than ", reumatic event, the Medi	ToE	James D. Grimes					Rose A	. Ford			
Mar 12 sho 12 sh		19a. Informant's Name/Relation						or Rural Route Num			
t and thealth		Sister Anne Mauree	en — Nun	20b, Place o	f Dispo	sition (Name of		Marriotts		MD. 2110	
ages ent of nt: If it		1 M Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (State cemete	ry, cren	al Cemetery		02/04		imore, Mar	
Baltimore, Me permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service		THEW CLIE	_		, .	of Catonsvi			гулана
a 88 a 8		Bit	YOU	MM869	16	530 Edmonds	on Aven	ue: Catonsvi	ille, i	LDC. ☑D. 21228	
THE SAME		23a Part1. Enter the disease, of hock, or heart it ilure. Lis	or complications that tonly one cause on	caused the death. Do earn line.	not ente	er the mode of dying	g, such as ca	ardiac or respiratory	arrest,		Approximate Interval Between
Physician. /Medical		Immedia Final disease or condition resulting in death)	a			ascular	A	ccident			Onset and Death
Examiner			Due to	(or as a consequence							
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to	(or as a numbrouence	of):	SION					
8760, sate be executed only sician and the burial-transit	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	c								
8760, cate be exemply sician a	ai Ey	resulting in death) Last	Due to	(or as a consequence	of):						
687 ifficate g physias the	edicai		d.	152							
Box 6i	n/M	IF FEMALE: 23b. Was decedent pregnant		itcome of pregnancy						23d. Date of deli	verv
O. B. ne death the atternate hed for	Physician/Me	in the past 12 months? 1 □ Yes 2 ☑ No		birth 2 Fetal death nant at time of death		Ectopic pregnancy Other (specify)				Month	Day Year
that the deed by the detached		9 ☐ Unknown Part II. Other significant condit.			- 15-0	d-ab :	- in Death	00- Did	4-1		
d be	d by	arth, other signmount contain	ions contributing to t	Jean Dut not resulting II	n merun	derlying cause give	n in Part I.		Yes 2	,	the cause of death?
cor w requ	Completed							24a. Was	s an	24b Were aut	opsy findings available
I Re(The laverate has page 2	mo							auto	opsy ormed?	prior to death?	ompletion of cause of
	BeC	25. Was case referred to medica examiner?	31				26. Place o	1 ☐ Yes f Death (Check only		TLI Yes	2 NO
of Vita Physician: this certific al director,	P.	1 ☐ Yes 2 ☑ No		Inpatient 2 ☐ ER/Ou				ing Home 5 Res	idence 6	S □Other (Spec	ify)
on of ding F	ion:	27. Manner of Death 1 ■Natural 5 ■ Pendi	ng 28a. Date (Mor igation		Fime of njury	28c. Injury Work M 1 □ Y	at ? ′es 2∐No	28d. Describe	how injury	occurred	
Division of Vita to Attending Physician: after death. Director: After this certific in by the funeral director.	fica	3 Suicide 6 Could	not be	e of Injury - At home, fa ling, etc. <i>(Specify)</i>	ırm, stre		83 2 LINC		(Street and	d Number or Rur	ral Route Number.
Div	Certification:	4 Homicide determ	build	ling, etc. (Specity)		,,		City or To	iwn, State))	
Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical (29a. Certifier 1 Certifyi (Check only one) 2 Medicel	Examiner: On the t	e best of my knowledge pasis of examination an iner stated.	death dor inv	occurred at the time estigation, in my op	e, date and i	place, and due to the occurred at the time,	cause(s) date and	and manner as place, and due t	stated. to the cause(s)
To ti To ti	Σ	29b. Signature and title of certific		۸		29c. License				e signed (Month,	*
		Dallah S	alalued	di M.D		D202	-52		-	101/00	-1
B		30. Name and address of person				,					
Sta	te	Dalien Salah 31. Date filed (Month Pay, Year	uddin, M.D.	20 Crossroads Registrar's Signature	s Dri			ings Mills,	MD. 21	117	
Registr		40 4 0 3	2004	Canava	B	Spare	2				

10:10 р.т.

		1 - For State Registrar	State of Maryland / De	epartment of H Certificate of I	lealth and M Death		eng 004	34627
Physi		1. Decedent's Name <i>(First, Middle, Last)</i> Helen Gavigan				2. Date of Death Month October	31, 2004	3. Time of Death 10:10 p M
/Med Exam		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Death		4c. County of Deat	
		Stella Maris Hosp:	ice	Timon	ium		Baltimo	
Funera Directo		5. Social Security Number 6. Sex 186-10-1426	M OFF	rs. If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Aug. 30,	1913 Pen:	nplace (State or Foreign untry) nsv1vania
ט		Usual Residence of Decedent						
anylar		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Ne M	ecto	Md. Harford	В	el Air				1 ☐ Yes 2 ☐ No
with t	P.	10e. Street and Number 1800 Falstaff Ros		10f. Zip Code	.015		g. Citizen of What Co United St	
death with the Maryland ms 23a or 28a-f show	Funeral Director		2. Was Decedent Ever in U.S.				14. Race - Ame	
DESIGNATION CE, METYIANG ZIZIS-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Items 23a or 28a-1 show any injury or other treumatic svent, It a Modical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	in, Mexican, Puerto Specify:	Rican, etc.)	Black, White	
72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. [Decedent's Usual Occupa	ation	16	6b. Kind of Business/	ndustry
Me ithin	npie	Elementary/Secondary (0-12)	College (1-40r5+)	Give kind of work done of life. DO NOT use retired		i		
led wit ygjene ygjene her the		12 years	te	lephone ope			ommunicat	ions
/Iana uld be file Mental Hy srked oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	o (First, Middle, Ma Lchards F		
hould d Mer marke	2	Patrick Flaherty 19a. Informant's Name/Relationship (Type	an Brintl	Mailine Address (Canada				
y Mal		Rosemary Mirabello		Mailing Address (Street a				ip Code)
ages 1 are not of Heart: If item		20a. Method of Disposition 1 Burial 2 Cremation 3XX	cemetery,	Disposition (Name of crematory or other place in Evangelis	e)		oc. Location - City or Pittston	
altimor		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License		22. Name and Addres		./4/01	TICEBEON	, 171
Departmi Departmi Import		Jan 2011	(Schimunek	Funeral		Bel Air, Air, Md.	
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. Do no	ot enter the mode of dying	g, such as cardiac o	r respiratory arrest	i,	Approximate Interval Between
Fnysician	_	Immediate Cause (Final disease or condition	CONGESTIVE HEAR	T FAILURE				Onset and Death
/Medica Examine	_	resulting in death)	Due to (or as a consequence of	Contract to the second				
		Sequentially list conditions, if any leading to immediate	Due to (or as a consequence of	1:				
nsit	J in	Sequentially list conditions, if any, leading to immediate cause. Enter or serving Cause (Disease or injury that initiated events	220 10 (01 00 0 001000000100 01)	,.				
be execuician and burial-trai	Examiner	resulting in death) Last	Due to (or as a consequence of):				
icate be executed physician and sthe burial-transit	cai							İ
difficate	ed	IEEE NAME						
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of delin Month	very Day Year
s that	by P	Part II. Other significant conditions con	tributing to death but not resulting in t	the underlying cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
w requires been sign should be						1 🗆 Yes	2 □ No 3 □ Pro	babiy 4 Dinknown
VICAL NECC sicien: The law re certificate has be lirector, page 2 sho	Completed				 	24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
VICALI icien: T sertificate ector, pa	0	25. Was case referred to medical			26. Place of Death		No 1 ☐ Yes	2 No
ysicie s cer direct	B	examiner?	ospital:	patient 3 DOA Othe			ce 6 YOther (Spec	(v) HOCDTOR
tending Physicath. tor: After this the funeral di	tion; T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Tin	me of 28c. Injury	at 2	28d. Describe how		HOSPICE
Attended death ctor:	ficat	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm			28f. Location (Stree	et and Number or Rui	ral Route Number.
s after s long s	Certification;	4 Homicide	building, etc. (Specify)	,,,,,,		City or Town, S		
To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	icien: To the best of my knowledge, oner: On the basis of examination and/orand manner stated.	death occurred at the tim or investigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
To t withi To ti	×	29b. Signature and title of certifier		29c. License	number		. Date signed (Month	, ,
		1 /2		1243	3725		11/1/09	
.6	1	30. Name and address of person who cor	npleted cause of death (Item 23a) (Ty	ype, Print)				
1	7	DR. TARIQ MAHMOOD 31. Date filed (Month, Day, Year)		ALLEY RD.	TIMONIUM,	MD 21093	3	
S Regis	tate trar	NOV 0 3 20	32. Registrar's Signature	& Sport				
1,6913	Al-al-	100 03 20	1	~ Apour				

			1 - For State Registrar	State of M	aryland / Depa	artment of h	leaith and N	Mental Hyg	iene2004	34628
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, Emil 4a. Facility Name (If not institution,	Granit	3KI	4b. City, Town, or	r Location of Death	2. Date of Deat Month		3. Time of Death 4:00 AM
	Funeral Director	lei	2500 Fox Road 5. Social Security Number 161–26–7754		ge (In yrs. last birthday) 71 Yrs.	Fallst If Under 1 Year Months Days		8. Date of Birth (Month, Day, 05/31/1	Harfore	
	h the Maryland r 28a-f show	irector	Usual Residence of Decedent	rd	10c. City, Town or Lo			10	0g. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 🌠 No
9036	n 72 hours after death with the Maryland "natural", or Items 23e or 28a-f show wheal Exprimer rust be multiled at	d by Funeral Director	2500 Fox Road 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced		NoKoran	21047 Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	U.S.A. 14. Race - Ame Black, Whit Specify: WI	
21215-0036	d within giene. ir then "	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or	(Give 5+)	dent's Usual Occupi kind of work done of DO NOT use retired	turing most of work iple	ing	16b. Kind of Business Baltimore (
Maryland	d o d o	To Be	17. Father's Name (First, Middle, La Arthur Granitzk 19a. Informant's Name/Relationshi	i	19b. Mailir	ng Address (Street a	Florer	e (First, Middle, M NCE Probs al Route Number,	,	Zip Code)
Baltimore, N	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 Is marke eny injury or other treumetic Once.		Jane N. Granit. 20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Spe	B □Removal from State	20b. Place of Disponsion Rock Spri	ing Cemetors of Address Name and Address	ery 11/0	3/2004_ F. Lass	laryland 2 200. Location - City or Forest Hil sahn Funera 111e, Maryl	Town, State 1, Maryland al Home, P.A.
The same	Fnysician /Medical Examiner		23a. Part1. Enter the disease, of consher, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a Due to (or a	the death. Do not ent ne. Stole	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
8760, 5	ite be executed sysician and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Cach	COBSTUCE a consequence of): e XIA a consequence of): x ALMIA	tive ruli	monany	Disea.	se .	10 YKS.
P.O. Box 6	The law requires that the death certifics ate has been signed by the attending phage 2 should be detached for use as It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	very Day Year
Records, P	n requires that the de been signed by the should be detached	þ	Part II. Other significant condition		ut not resulting in the un	nderlying cause give	en in Part I.		acco use contribute to s 2 □ No 3 □ Pr	the cause of death?
ital Red		Be Completed	25. Was case referred to medical examiner?				26. Place of Death	24a. Was an autopsy perform 1 Yes 2	prior to death? No 1 Yes	topsy findings available completion of cause of
Division of Vital	or Attending fter death. Director: After in by the funer	Certification: To I	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no determin	t be	y Year) 28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? /es 2 \(\text{No} \)	28d. Describe hov	eet and Number or Ru	
_	To the Hospitel within 24 hours a To the Funerel completely filled	Medical Co	one) 2[] Medical Ex	Physician: To the best caminer: On the basis of and manner sta	examination and/or inv	estigation, in my op	inion, death occurr	ed at the time, da	te and place, and due	to the cause(s)
		•	29b. Signature and title of certifier 30. Name and address of person when the certifier of		eath (Item 23a) (Type,		18424	-	d. Date signed (Month	
	Sta Registr	te ar	B. Parekh MD 31. Date filed (Month, Pay, Year) NOV 03	. 1908 H	tarford	Long				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 34629 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 28, 2004 10:20 am Mary Isabelle German /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner Perry Hall Baltimore Oak Crest Care Center If Under 1 Year 8. Date of Birth (Month, Day, Year) Dec 25, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. Months 1 ☐ M 25 F Yrs 89 1914 Canada Director 216-32-2485 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland to thealth and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "naturel", or items 23s or 28s-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Perry Hall Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21128 9424 Kilbride Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yas 2 No Specify. Baltimore. Maryland 21215-0036 Specify: If Yes, Give Year or Dates: ģ 3 N Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Retail Sales (Millinary) 12 n/a 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bullock Margaret McGrow ပ George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) . rtment of Health rtant: If Item 27 I 9424 Kilbride Court, Perry Hall, MD M. Norma Lane/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/2/04 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lakeview Memorial Park 21. Signature of Funeral Service License 22. Nama and Address of Facility Lemmon Funeral Homne 10 W. Padonia Road, Timonium, MD 21093 Bryan W. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/failure. List only one cause opeach line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner ettending physicien end i for use es the bunel-trensit The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed ģ should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed been a) KNO 1 ☐ Yes 2 ☐ No f LI Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: oursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Certification: To this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Division of Vital Records, P.O. Box 68760

German

: After this funeral Attending Fer deeth. To the Hospital or Attendin within 24 hours efter deeth.

To the Funeral Director: Af completely filled in by the fu

29b. Signature and title of certifie

6 Could not be

29c. License number

critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Description of the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s)

29d. Date signed (Moath, Dey, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Parkville,

30. Name and addless of person completed cause of deeth (Item 23e) (Type, Print 800 avvo Ja

and manner stated.

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, Year) State NOV 03 2004 Registrar

edical

3 ☐ Suicide

4 Homicide

(Check only one)

			For State Registrar	State of Maryland		artment of rtificate of			giene 2004	34630
	D		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea	ath Day Year	3. Time of Death
	Physici /Medic		Lloyd Grant	Griffith, Sr.					27, 2004	12:47 P M
and the same	Examin		4a. Facility Name (If not institution, give				or Location of Death		4c. County of De	ath
		•	205 Glenbrook Dr				ninster		Carro1	
	Funeral Director		231-24-2409	7. Age (In yrs. Ia.	st birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birt (Month, Da) Dec 29	1000	irthplace (Stete or Foreign Country) Loginia
	and and		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	ocation				10d. Inside City Limits
	fsho	ō	MD Carroll	1.7	estmi	nator				1 ☐ Yes ZX No
	the 288	Director	10e. Street and Number	- 1	CSCIIIT	10f. Zip Code			10g. Citizen of What 0	Country?
	3a of	Ö	205 Glenbrook	Drive		2115	8		United Sta	ites
21215-0036	d within 72 hours after death with the Maryland jiene. r then "neturel", or terms 23a or 28a-f show the Medical Evertiret rest be neithed at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 (ঐYes 2 ☐ No If Yes, Give Year or Dates: WWI		Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ② No	Hispanic Origin? (Spe iban, Mexican, Puerto I o <i>Specify:</i>	cify Yes or No- Rican, etc.)	Black, Wh	
9	72 ho	ted	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occi	upation e during most of working	20	16b. Kind of Busines	s/Industry
21	thin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	red)	<i>'</i> 9		
2	77 75 10	Completed		0	Self	Employe			Home Impro	vement
Maryland		To Be	17. Father's Name (First, Middle, Last) William Mack Gr	iffith			18. Mother's Name Minnie		•	
a	and and s m		19a. Informant's Name/Relationship (7	(Spouse)	19b. Maili	ng Address (Stree	et and Number or Rura	l Route Numbe	r, City or Town, State,	Zip Code)
	1 and 2 Health i		Charlotte Elizab				ok Drive,	Westmin	ster, MD.	21158
ore	m O		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domesial from State Cel	netery, crei	sition (Name of matory or other pi	lace)	ate	20c. Location - City of	r Town, State
Ĕ	nit. Pages partment of l ortant: If its injury or o		`4 □ Donation 5 □ Other (Specify			_	tery 11/0			, Md. 21208
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licen	S00			ress of Facility Lor rty Road,			
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death.			-	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	sains).	06	1001	PUNC			Onset and Death
*	/Medical		resulting in death)	Due to (or as a conseque	ence of):	-	3			
	Examiner		Sequentially list conditions	6 Chroni	C (1200	Disc cal	2		
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseque	ence of):					
	rans	Examiner	that initiated events	C						
0	be executed sician and burial-transit		resulting in death) Last	Due to (or as a conseque	ence of):					
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89	ndiffica ng pl	Med	IF FEMALE:							
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	res that I igned by be deta		Part II. Other significant conditions of		ting in the u	nderlying cause g	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
sp	uires sigr ld be	d b	Tobucco	BOSE				1)24	es 2 □ No 3 □ F	Probably 4 Unknown
Vital Records,	w require been signature should b	Completed by						24a. Was	an 24h Were s	autopsy findings available
Re	has ge 2	m d m						autop	sy prior to death?	completion of cause of
a				<u> </u>				1 ☐ Yes	2 No 1 □ Ye	
V:	sician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Place of Death			_
of	Phys this al di	. To	1 Yes 2 No	1 Inpatient 2 E	R/Outpatier 28b. Time o	IL ST DOA	4 Indising Hon		lence 6 Other (Sp low injury occurred	ecify)
L C	ding Ph h. After th funeral	ion	1 Natural 5 Pending	(Month, Day Year)	Injury	W	ork? □Yes 2□No		ow injury occurred	
Sic	death death tor: / the	icat	3 Suicide 6 Could not be	28e. Place of Injury - At hom	ne farm str		1	8f Location /S	Street and Number or F	Rural Route Number
Division	or A after Direction by	Certification:	4 Homicide determined	building, etc. (Specify)	io, iaiii, sti	eet, ractory, ornor		City or Tow	n, State)	10010 14011001,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier 12 Certifying Ph	ysician: To the best of my know	ledge, deat	h occurred at the	time, date and place, a	nd due to the o	cause(s) and manner a	is stated.
	ne Ho ne Fu bletely	Medical	(Check only 2 Medical Exam	niner: On the basis of examination and manner stated.	on and/or in	vestigation, in my	opinion, death occurre	ed at the time, o	date and place, and du	e to the cause(s)
	To the To the To the Comp	ž	29b. Signature and title of certifier	. /		29c. Licer	nse number		29d. Date signed (Mor	th, Day, Year)
	1		Muld 13	Missoull	141	(0	14753		10/29/	64
-	101		30. Name and address of person who	completed cause of death (Item 2	23a) (Type,	Print)				
	/~		795 A WO	chart P	_c a	S, C	lon V	200 2	11.916	0.21061
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registar's Signatu	ire	4 Los	de		(
	negisti	TEII .			/"	Land of the said				

		•	State of Maryla State Registrar	ind / Depa <i>Cer</i>	artment of Health and tificate of Death	Mental Hygie	2004	34631
	Physici	an	1. Decedent's Name (First, Middle, Last)			•	Day Year	3. Time of Death
	/Medic	al	Martin J. Garrity 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of De	ath October 2	 200 4 4c. County of Death 	
	LAGIIIII	CI	University of Maryland Medical Sys	:tem	Baltimore		Baltimore	e City
	Funeral Director		216-36-0931 ¹⊠ ^M 2□ F 62	rs. last birthday) Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi	n. (Month, Day, Ye	ar) Cou	place (State or Foreign intry) y land
	ow ow		Usual Residence of Decedent 10a. State 10b. County 10c.	City, Town or Lo	cation			10d. Inside City Limits
	a-fsh	ctor	MD	Baltimor	e			1 X Yes 2 □ No
	with the	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cou	intry?
	eath v	Funeral	11 W. 20th Street 11. Marital Status 12. Was Decedent Ever in	U.S. 13.V	21228 Was Decedent of Hispanic Origin?	(Specify Yes or No-	USA 14. Race - Ameri	ican Indian.
036	urs after d al', or Itan Examinat	by Fun	1 XNever Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	15	f Yes, specify Cuban, Mexican, Puo I ☐ Yes 2X No Specify:	erto Rican, etc.)	Black, White	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. The Medical Examinat must be notified at ODGe.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk	(Give	lent's Usual Occupation kind of work done during most of w OO NOT use retired)	vorking unk 16b	. Kind of Business/Ir	ndustry unk
Maryland 2	d be filed ental Hygir ted other c avant, I	Be	17. Father's Name (First, Middle, Last)		unk 18. Mother's N	ame (First, Middle, Maid	fen Sumame)	unk
ary	should and Me s mark umati	To	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	ng Address (Street and Number or	Rural Route Number, Ci	ty or Town, State, Zi	ip Code)
	of Health au itam 27 is other trau		UMMS	22	S. Greene Stree			
Baltimore,	Pages 1 ment of H ant; If ita		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) in state		sition (Name of natory or other place)	Date 20c	. Location - City or T	own, State
Ball	permit Depart Import any in		21. Signal with Licensee Rona I S. Wade, Diff con	3r St Ba	Name and Address of Facility ate Anatomy Boar 1timore, MD 212	rd 655 W. B.	altimore S	Street
П			23a. Part1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line.		95.00			Approximate Interval Between Onset and Death
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ds, P.O.	uires that the signed by id be detacted		Part II. Other significant conditions contributing to death but not read ocarditis	esulting in the un	nderlying cause given in Part I.		co use contribute to t	4
Vital Records,	aw requir is been si 2 should	Completed by	Hepatitis C Osteomyelitis	ريم.		24a. Was an	24b. Were auto	opsy findings available
l Re	The lav ate has page 2	Com	Osteomyelitis 1/3/1/21/			autopsy performed	? death?	ompletion of cause of
Vita	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?			eath (Check only one)		
o	는 다 E	tion: To	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Home 5 Residence 28d. Describe how in		fy)
Division	l or Attano after death Diractor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - Al building, etc. (Spe	home, farm, stre		28f. Location (Street City or Town, St		al Route Number,
	To tha Hospital or Attanding Phwithin 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	edicai C	29a. Certifier (Check only one) Certifying Physician: To the best of my k Check only one) Certifying Physician: To the best of my k Certifying Physici					
	To th withir To th comp	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
			MA MO		15795		tober 20	
			30. Name and address of person who completed cause of death (II Jennifer P. Taylor, MD	em 23a) (Type, I	S. Greenes Sporks	t. Baltimo	re, MD	21201
	Sta Registi		31. Date filed (Month Day Year) 4	matura	Sparks		-	

			1 - For State Registrar	te of Maryland /	-	artment of H tificate of L			ene g. n2 0 0 4	34632
	Dhysisi		Decedent's Name (First, Middle, Last)				_	2. Date of Death Month	1	3. Time of Death
	Physici /Medio			J	Gmı	ırek		October		4 1212 PM
	Examir	er	4a. Facility Name (If not institution, give street a 2009 Norhurst Way	South		4b. City, Town, or Catons	ville		4c. County of De Baltin	
	Funeral Director		5. Social Security Number 6. Sex 1 2 1 4 - 2 6 - 3 8 4 9 Usual Residence of Decedent	7. Age (In yrs. last I	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. B MA	irthplace (State or Foreign Country) RYLAND
	yland		10a. State 10b. County	10c. City, To	wn or Lo	cation				10d. Inside City Limits
	e Mar	ctor	Md. Baltimore	Cat	onsv	/ille				1 ☐ Yes 2X No
	with th	Funeral Director	10e. Street and Number	- C- 11		10f. Zip Code		10	g. Citizen of What (Country?
	ns 23	erai		Decedent Ever in U.S.	13. \	212 Was Decedent of Hi		Specify Yes or No-	USA 14. Race - An	nerican Indian,
920	filed within 72 hours after death with the Maryland Hygliene. ther then "naturel", or Items 23a or 28a-f show int, the Mudical Evarili art must be Indiffied at	by	1 □ Never Married 2 ▼ Married 1 □ If Y	ed Forces? Yes 2 ⊠ No es, Give r or Dates:		f Yes, specify Cuba I□Yes 2∑XNo	n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, Wh	
21215-0036	be filed within 72 hours hal Hygiene. Id other then "naturel", event, the Medical Eva	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	(Give	ient's Usual Occupa	luring most of w	orking 1	6b. Kind of Busines	s/Industry
121	within ane.	idui		ege (1-4or 5+)	life. I	00 NOT use retired ASTER PI)		SELF	1
d 2	e filed within al Hygiene. I other then ' vent, the Me	Be Co	17. Father's Name (First, Middle, Last)		1.17	ASTER II		ame (First, Middle, M		
ylar	2 should be f and Mental H is marked of raumetic ever	To B	Adam J. Gmurek					nia Sambo		
, Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumetic		19a. Informant's Name/Relationship (Type, Prin Dolores Gmurek (w.	ife) 20	9b. Mailir 009	g Address <i>(Street a</i> Norhurs	nd Number or F t Way	Rural Route Number, South Ba	City or Town, State, lltimore	Zip Code) , Md 21228
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)			sition (Name of			Oc. Location - City o	
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	Jesu	22		s of Facilitya C		Funera	1 Home, PA
	*		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do						Approximate Interval Between
	Physician		Immediate Cause (Final	LF INFLICTE ue to (or as a consequence		_				Onset and Death
B	/Medical Examiner		resulting in death)	ue to (or as a consequenc	e of):	J	•			
Ш	sit ad	iner	Sequentially list conditions, and search and	ue to (or as a consequenc	e of):					
oʻ	cate be executed bhysician and the burial-transit	Examin	that initiated events resulting in death) Last	ue to (or as a consequenc	e of):					
8760,	phy:	dicai	d							
9 XO	death certific e attending p id for use as	an/Me	23b. Was decedent pregnant	es, outcome of pregnancy Live birth 2 ☐ Fetal dea	th 3	Ectopic pregnancy			23d. Date of de	elivery
O. B		Physician/Me	1 Ves 3 No	Pregnant at time of death Unknown		Other (specify)			Month	Day Year
rds, P	The law requires that the tee has been signed by thi sage 2 should be detache	by	Part II. Other significant conditions contributin	g to death but not resulting	in the ur	nderlying cause give	n in Part I.	23e. Did toba		to the cause of death? Probably 4 Dunknown
Records,	The law reate has bee page 2 sho	Completed						24a. Was an autopsy perform	prior to death?	
Vital		BeC	25. Was case referred to medical examiner?				26. Place of De	1 ☐ Yes 2 [eath Check onl one		s 🏋 No
of V	S S	၉	1 XYes 2 No Hospital			t 3□ DOA Othe	4 Li Nursing	Home 5 Residen		ecify)
	ling After une	tion	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Time of Injury	28c. Injury Work 2 M 1 □ Y	? _/	28d. Describe how	injury occurred	6.3
Division	I or Attending after death. Director: After I in by the fune	Certification;	C Could not be	Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (Stree City or Town,	et and Number or F	lural Route Number,
	ital or A irs after rel Direc led in by	Cert		ItomE 2009				2409 NOR		ATONS 87 LLE
	Hosp 24 hou Fune stely fil	Medical	29a. Certifier (Check only one) 1 Certifying Physicien: 2 Medical Examiner: On and	To the best of my knowledge the basis of examination a I manner stated.	ge, death and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occ	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the Hospital or A within 24 hours after To the Funerel Direct completely filled in by	Mec	29b. Signature and little of certifier	mannor stateu.		29c. License	number	290	d. Date signed (Mon	th, Day, Year)
	1		1 1 1000 GIA	RINTAIN		2/1	191	N	ovember	1, 2004
	V		30. Name and address of person who completes	cause of death (Item 23a) (Туре, і	Print)	/ -			
		10	31. Date filed (Month, Day, Year)	32. Registrar's Signature	5 30	T. VOLAS	LANE	1=44; co	TC 174, 11	1ARYLAND 2,042
	Sta Registr		NOV 0 3 2004	Severe	G	Scarle	1		,	21042

			State of Maryland / Department of Health		lygiene	
			1 - State Registrar Certificate of Death		Reg. No.	34633
	Physicia	an	1. Decedent's Name (First, Middle, Last) GEORGE HOLCOMBE	2. Date of Month	Day Yea	0 1 1 1 1 1 1 1 A
	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location		4c. County of De	
	LAGIIIII	C	BALTIMORE REHABILITATION EXTENDED CARE B	BALTIMOR	E NA	
	Funeral		Months Dave Hours	Min. 8. Date of (Month,	Birth 9. B	irthplace (State or Foreign Quintry)
_	Director		Usual Residence of Decedent	11-1	9–30	1E)
	yland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Ba-1 s	Director	Md. NA Baltimore			X□Yes 2□No
	with th	Dire	10e. Street and Number 10f. Zip Code		10g. Citizen of What (Country?
	eath v	erai	5806 Radecke Ave. 21206 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Or	rigin? (Specify Ves or	USA	nerican Indian,
980	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or tlems 23a or 28a-f show event. The Medical Examinar must be multiped at	by Funerai		an, Puerto Rican, etc.)	Black, Wh	
2-0	72 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during mo:	est of working	16b. Kind of Busines	s/Industry
21	within ene.	mpie	Elementary/Secondary (0-12) College (1-4or 5+)	of Working		
2	e filed within al Hygiene. I other than ' vent, Iha We			her's Name (First, Midd	Montebello	State
Maryland 21215-0036	lid be lental ked o	To Be		Jesse	Marie	Lee
ary	s 1 and 2 should be f Health and Mental item 27 is marked other traumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Numb			
	2 = 7 = 2	ĺχ	Audrey Marie Holcombe Wife 4602 Willshire A			21206
Baltimore,	Pages 1 ar	24	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3 Removal from State Garrison Forest VA	Date 11/3/2004	20c. Location - City of Owings M	or Town, State Iil MD
Him	그 분 된 근		* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facil	iliby		
Ba	permi Depa Impo any ir		March F.H. Eas	t 1101	altimore, Mo E. North Ave	.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Immediate Cause (Final		r arrest,	Approximate Interval Between Onset and Death
	Pnysician /Medical	ľ	Immediate Cause (Final disease or condition resulting in death) a. CANCER PANCREAS			2 years
	Examiner		Due to (of as a consequence of).			
	n =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
16	be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events c			
8760,	cate be execu physician and the burial-trai					
687	ficate physis the	edicai	d			
Вох	death certificate e attending phys of for use as the	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date of d	elivery
	at the deat by the att tached for	Physician/Me	in the past 12 months? 1		Month -	Day Year
<u>P</u>	that the ed by the detacher	Phy	Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part	23e. Di	d tobacco use contribute	to the cause of death?
Records,	v requires that been signed b should be deta	ted by			A 4	Probably 4 Unknown
	e law has b	ompieted		24a. W au pe 1 🗌 Yes	topsy prior to rformed? prior to	autopsy findings available completion of cause of
Vital	sician: Th certificate rector, pag	Bec	examiner?	ce of Death (Check onl		
of V	S S =	ပ္	1 ☐ Yes 2 💢 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 💢 No		esidence 6 Other (Sp	ecify)
	Jing After fune	tion:	27. Manner of Death 1 X Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation 2 Accident M M M 28c. Injury at Injury Work? 1 ☐ Yes 2 ☐		e how injury occurred	
Division	Attending er death. rector: After by the fune	fica	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f. Location	(Street and Number or F	Rural Route Number,
Ö		Certification:	4 Homicide determined building, etc. (Specify)	City or	own, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	edical (and place, and due to the time	ne cause(s) and manner a e, date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier 29c. License number	Bro	29d. Date signed (Mor	
			Kuna Ci (au, Itick- 1749	1>8	10-27-	2004
	411		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AURORA C. TAN 3900 LOCH PAVEN BOULEVAL	RD BAL	TIMORE, M	0 21218
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2004 Secret Signature & Sports	t ·	,	

		1 _ State	of Maryland / Dep	artment of Health				34634
a		Registrar 1. Decedent's Name (First, Middle, Last)		rimodic or bed		Reg. Date of Death	No 0 0 1	3. Time of Death
Physic /Med		VALERISE M	ICKOY H	OLLEY	0	Month	Bay 30, 200	1: 47 PM
Exami		4a. Fecility Name (If not institution, give street and	number)	4b. City, Town, or Location			4c. County of Death	
		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	If Under 1 Year If Under	imore	Date of Birth	N/A	place (State or Foreign
Funeral Director		217-74-4281 1 M 2XX	45 Yrs.	Months Days Hou		(Month, Day, Ye	ar) Cou	ntry)
put *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	acation				
Maryla	ō	MD Harford	Aberde					10d. Inside City Limits 1 ☐ Yes 2€No
h the or 28a	irec	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Cou	ntry?
ath wil	Funeral Director	3404 Churchville Ro		21001			USA	
ter de Items	nne	Armed	ecedent Ever in U.S. Forces? s 2 No	Was Decedent of Hispanic If Yes, specify Cuban, Mexi	Origin? (Specify ican, Puerto Ric	Yes or No- an, etc.)	14. Race - Ameri Black, White,	
be filed within 72 hours after death with the Maryland lal Hygiene. d other than "natural", or Items 23a or 28a-f ehow event, it a Modical Evaniner must be notified at	by	If Yes,	Give Dates:	1 ☐ Yes 2 【XNo Spec	cify:		Specify: Bla	ack
72 hc	Completed	15. Decedent's Education (Specify only highest grade complete	d) (Give	dent's Usual Occupation kind of work done during n	nost of working	16b	. Kind of Business/In	dustry
within ene. than	ld mc		(1-4or 5+)	ndependent C	an Co		Welder	
a filed Hygi other	Be Co	17. Father's Name (First, Middle, Last)	/A 1			irst, Middle, Maid		
2 should be filed within and Mental Hygiene is marked other than eumetic event, it e.m.	10 E	Charles L. McKoy			Eunice		МсКоу	
ges 1 and 2 should be filed within 72 hr to f Health and Mental Hygiene If item 27 is marked other than "nature or other treumetic event, the Madical		19a. Informant's Name/Relationship (Type, Print) Maurice Holley, Srhu		ing Address <i>(Street and Nui</i> 104 Churchvil				Code)
s 1 and F Healt He	1	20a. Method of Disposition	20b. Place of Disp	osition (Name of	Date		Location - City or To	
Pages nent of int: If i		1 ☑Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)		e Cemetery	11/7/20	004 C	ouncil	N.C.
permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tre sonce.	10	21. Signature of Funeral Service Licensee	2	2. Name and Address of Fa	acility MARO	CH FUNER	AL HOME-E	
- 007 0		23a. Part1. Enter the disease, or comblications that		101 E. North			re, MD	21202
1000		shock, or heart failure. List only one cause of	n each line.	ter the mode of dying, such	as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
Pnysician /Medical	1	resulting in death)	o (or as a consequence of):					
Examiner		Sequentially list conditions. b. Pul	monery Hy	pertension)			
ed ist	Examiner	cause. Enter Underlying	o (or as a consequence of):					
execul n and ial-trar	Ехап	that initiated events	o (or as a consequence of):					
The faw requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	Co.	ngestive t	reart for	ilure			
entifica ding pt	Med	IF FEMALE:	0					
eath certific attending p	ician/Me	in the past 12 months?		☐Ectopic pregnancy ☐ Other (specify)			23d. Date of delive Month	ory Day Year
that the de	hys	1 Yes 2 No 9 Unknown 9 Unknown						
res tha igned l	by P	Part II. Other significant conditions contributing to	death but not resulting in the u	inderlying cause given in Pa	art I.		o use contribute to the	
w requir been si should	eted					1 ☑ Yes	2 □ No 3 □ Prob	ably 4 □Unknown
ne taw ne taw s has b	Completed					24a. Was an autopsy performed?	prior to con	psy findings available appletion of cause of
	a)	25. Was case referred to medical		26 Ple	ace of Death (C	1□ Yes 2 🗹		2 No
Physicien: this certific al director,	To B	examiner? 1 \(\text{Yes} 2 \) No Hospital: 1	Inpatient 2 ER/Outpatier	Other			6 Other (Specifi	·)
ding Phy th. After thi funeral		1 Natural 5 Pending (Me	e of Injury 28b. Time onth, Day Year) Injury	Work?		Describe how in	jury occurred	
or Attend after death Director: / in by the f	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e, Pla	ce of Injury - At home, farm, st	M 1 ☐ Yes 2		Location (Street	and Number or Rura	l Route Number
el or / s after s after od in b	Certification;	4 Homicide determined bui	ding, etc. (Specify)			City or Town, Sta	ate)	Thouse Wallinger,
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edical (29a. Certifier 1 Certifying Physicien: To t	basis of examination and/or in	h occurred at the time, date vestigation, in my opinion, o	and place, and death occurred a	due to the cause	(s) and manner as st	ated. the cause(s)
o the vithin 2 o the comple	Med	one) and ma	inner stated.	29c. License numbe			Date signed (Month,	
F > F 0		Pa Open	mD.Pt	N AU 41764	35D15			
П		30. Name and address of person who completed ca	use of death (Item 23a) (Type,	D AU 41764 S. Greene	,	-	7700 00	, 0007
	ate		Php 22 Registrar's Signature	S. Greene	Stree	+ Baltin	now wE	21201
Regist		NOV 0 3 2004	Beneva &	Souls				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	faryland / Dep <i>Ce</i>	artment of H	lealth and Death	Mental Hy	giene Reg. No.	004	34635
	Physici	an	Decedent's Name (First, Middle, Last,					2. Date of De Month	Day	Yeer	3. Time of Death
	/Medic	al	Lucille 4a. Fecility Name (If not institution, give		el .	4h City Tourn or	Location of Doc			004	6:20a [™]
	Examin	er	Villa St. Michae		7)	4b. City, Town, or	imore	(n	4c. U	ounty of Death $\mathrm{N/A}$	
	Funeral		5. Social Security Number 6. Sec	7. 4	Age (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs	8. Date of Bi	rth .	9. Birth	place (State or Foreign
	Director		578-46-0236 ¹⁰	M 2 F	87 Yrs.	Months Days	Hours Min.	8. Date of Bi (Month, Di OCT 7,	1917	Sout	ch Carolina
	pur A		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or L	ocation					10d. Inside City Limits
	Maryik f sho ied a	o.	Maryland Balti	more		ynn Oak					1 ☐ Yes 2 X No
	1 the 7 286	Director	10e. Street and Number	MOLE	Gw	10f. Zip Code			10g. Citize	n of What Cou	intry?
	7 with	ai D	6701 Townbrook D	rive Apt	. B	212	:07		Ţ	JSA	
	ems	Funeral I	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	specify Yes or No	o- 14	. Race - Ameri Black, White	
36	s afte	ьу Fu	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	1 Tes 2 I	ZNo	1 ☐ Yes 2 📉 No	Specify:	,			Black
8	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Madical Evandar must be notified at	ed p	15. Decedent's Edu	Year or Dates		dent's Usual Occupa	ation	<u> </u>	16b Kind	of Business/Ir	odustry
215	nin 72 nn ne Medik	plet	(Specify only highest grad	e completed) College (1-4o	(Give	kind of work done of DO NOT use retired	during most of wo	rking	Tob. Italia	or Edoniood ii	iddolly
21	e filed within al Hygiene. I other then '	Completed	Unk.	oonege (1 te	Но	usekeepin	g		Clea	aning S	ervice
Maryland 21215-0036	be filed within 72 hours after death with the Marylan at Hygliene. Id other than "naturel", or litems 23e or 28e-f show of other than "naturel", or litems 23e or 28e-f show event, the Medical Evanthar must be notified at	Be	17. Father's Name (First, Middle, Last) Armsty Harris					me (First, Middle	, Maiden Si	umame)	
7	2 should be and Mental Is marked c	ဥ	19a. Informant's Name/Relationship (Ty	ing Print)	10h Maili	ng Address (Street a		e Brown	as City as 7	Farm Chair 7	- Cod-l
Ma	D = 1 = 0		James Harris/son	pe, Friittj							
Ē,	s 1 and if Health item 27 other tr		20a. Method of Disposition	to	20b. Place of Dispo	Townbroo	W DITAG	Date D	20c. Loca	tion - City or T	own, State
E	Page net o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F `4 ☐ Donation 5 ☐ Other (Specify)	lemoval from Stat		ematory,	Inc. 11	./1/04	Balt	imore,	MD
Baltimore,	permit. Pages 1 an Department of Heal Importent: If item 2 eny Injury or other once.		21. Signature of Fine al Service Licens	MICHIPA		Name and Address Cremation				Inc.	
			23a. Part1. Enter the disease, or compl	Donald ications that cause	ed the death. Do not en	299 Frede ter the mode of dying	TICK ROA g, such as cardia	d Balt: c or respiratory a	imore, rrest,	MD 21	Approximate
	Pnysician ₁		shock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each	DEME	NITIA					Interval Between Onset and Death
	/Medical		resulting in death)		is a consequence of):	17000					
	Examiner	L	Sequentially list conditions,	CE	REBRO VA	SCULAR	Accie	ENT			
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	e a ecneaquanea oi).						
-	al-trar	Examiner	that initiated events resulting in death) Last	Due to (or a	s a consequence of):						
8760,	cate be executed physician and the burial-transit	dicai E		d							
9	ortifica ing ph e as th		IF FEMALE:								
Вох	death certific e attending p od for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death 3	Ectopic pregnancy			230	d. Date of delive Month	ery Day Year
0	0 0	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4☐Pregnant 9☐Unknown	at time of death 5[Other (specify)				Month	Duy Tour
<u>α</u>	requires that the d een signed by the hould be detached	/ Ph	Part II. Other significant conditions con	ntributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did t	obacco use	contribute to t	he cause of death?
Vital Records,	quires n sign	d by	HYPERTENSION	(1 🗆 '	Yes 2□!	No 3□Prot	pably 4 DUnknown
CO	> 0 0	ompleted						24a. Was		24b. Were auto	ppsy findings available
R	0 - 0	mo							ormed?	prior to co death? 1 🗌 Yes	mpletion of cause of
/ita	Physicien: Th this certificate ral director, pag	Be C	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only o			
	Physic this or	၉	1 ☐ Yes 2 No	lospital: 1 🗌 Inpat			4 M Nursing F	lome 5 🗆 Resi			ý)
uc	ding F	ion:	27. Manner of Death 1 Accident investigation	28a. Date of In (Month, D	jury 28b. Time o lay Year) Injury	Work		28d. Describe	how injury o	ccurred	
Division of	Attending or death. sector: After by the fune	ficat	3 Suicide 6 Could not be	28e. Place of Ir	njury - At home, farm, st		2010	28f. Location (Street and N	lumber or Rura	al Route Number,
Ö	rs after el Dire	Certification:	4 Homicide	building, e	etc."(Specify)			City or To	vn, State)		
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying Physical Condition 2 Medicel Examination (Check only)	sicien: To the bes ner: On the basis and manners		vestigation, in my op	inion, death occu	rred at the time,	date and pla	ace, and due to	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier			29c. License	number		29d. Date s	igned (Month,	Day, Year)
			The Chelenal		15	D006	0560		OCTUB	ER 30,	2004
	1				death (Item 23a) (Type,	29c. License D 8 0 6 Print) CK FIVER	Alichan	0, 0	1	4D 0 2' 1 4	٨
	Sta	te	PANICAJ KITE TE 31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	e FIVER	IVELK	170 · [146(1/h	IVLE IN	<u>')</u> .
	Registr		NOV 0 3 2	004	trar's Signature	door	les				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. e of Maryland / Department of Health and ental Hygiene 34636 1- Stote Amend item 2 per phys g837 11c2 Thate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Da@Teath 31, 2004 3. Time of Death William 0415 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth (Month, Day, Year) 03/01/1943 Baltimore ical evas If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M 2□ F 215-40-4194 North Ćarolina Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 XYes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1914 E. Lafayette U.S.A. Ave. 21213 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Security Guard Security 3 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Marion Hart Louise Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Clinton / Sister 1912 E. Lafayette Ave. Baltimore, Maryland 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/03/2004 Baltimore, Maryland Metro Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 4611 Park Heights Ave. 21. Signature of Funeral Service Licenses The Derrick C. Jones F/H, P.a. Balto., MD 21215 rantne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kespiraton taller disease or condition resulting in death) Due to (or as a consequence of): Anne 1.15

Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s been signed b cate has certificate Hospital or Attending Physician: After this certific funeral director, within 24 hours after dean.

To the Funeral Director: After the funeral pipe for

Physician

/Medical

Examiner

Direct

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Completed

Be

Funeral

Director

item 27 is marked other than "natural", or items 23s or 28s-1 show other traumstic event, the Nedical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be nent of Health and Mental

permit. Pages Department of Important: if it any injury or o once.

Physician

/Medical

Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)	quence of): _5+atic	Colon Can	CV		
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 MeNo 9 Unknown	23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3 Ectopic	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by Ph	Part II. Other significant conditions co	ontributing to death but not re	sulting in the underlyin	g cause given in Part I.	23e. Did tobacc		to the cause of death?
Complet					24a. Was an autopsy performed 1 Yes 2 😭	prior to death?	utopsy findings available completion of cause of s 2 \(\sum \) No
To Be (25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Unpatient 2	☐ER/Outpatient 3☐	The second secon	eath <i>(Check only one)</i> Home 5 Residence	e 6 □Other (Sp	ecify)
atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		
ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, street, fac ify)	tory, office	28f. Location (Street City or Town, St		Rural Route Number,
Medical Certification:	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner of the cause (s) and manner of the cause (s) and manner on the cause (s) and manner of the cause (s) and man						
Me	29b. Signature and title of certifier	liewes/		29c. License number Au 417le435	115-6.13	Date signed (Mon	th, Day, Year)
	30. Name and ddress of person who d	completed cause of Inth (Ite	m 23a) (Type, Print)	6		()	4 4

301 St. Paul Pl. Balto. Md. 21202

DHMH 17 Rev 1/2001

State

Registrar

30. Name and ddress of

31. Date filed (Month, Day,

MOV 0 3 2004

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32. Registrar's Signature

			_ FUI	epartment of Health and Menta Certificate of Death	Hygiene 004	34637
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Mo	e of Death nth Day Year	
	/Medic	al	John Alfred Hoy, D.D.S. 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	ober 30, 2004	12:03 P ^M
	Examili	ei	St. Joseph Medical Center	Towson	Baltin	nore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 213-38-9146 94	Months Days Hours Min. (Mo	e of Birth 9. Birth (19. Birth, Day, Year) Per	rthplace (State or Foreign country)
	Director		Usual Residence of Decedent		2 20, 1910 FeI	
	show	'n	10a. State 10b. County 10c. City, Town	_		10d. Inside City Limits 1 ☐ Yes 2√€No
	r 28a-f	Director	Md. Baltimore 10e. Street and Number	Towson 10f. Zip Code	10g. Citizen of Whal C	Country?
	23a o	alD	1055 West Joppa Road Apt. 402	21 204	USA	
	ltems	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 1	13. Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, o	s or No- etc.) 14. Race - Am Black, Wh	
936	72 hours after death with the Maryland insture!', or Items 23a or 28a-f show josal Exactronat ba rollised at	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 💢 No Specify:	Specify:	White
15-0	n 72 h	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Busines	s/Industry
212	d withi	omb	Elementary/Secondary (0-12) College (1-4or 5+) 5+	Dentist	Dentis	try
Maryland 21215-0036	be file	Be	17. Father's Name (First, Middle, Last)		Middle, Maiden Surname)	
Ž	should nd Mei mark	으	Harvey Howard Hov 19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b.	Mary Planta Mary Planta Mary Planta Mariang Address (Street and Number or Rural Route	asterer Number, City or Town, State,	Zip Code)
₹,	and 2 ealth a n 27 ts				on, Maryland 2	
Baltimore,	pormit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dopertment of Health and Mental Hygiene. Importent: if Item 27 is marked other than "neturel", or Items 23a or 28a-f show amy injury or other treumatic event, It a Musical Exacting must be rediffed at ance.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	Disposition (Name of pace) Date	20c. Location - City of	
ati.	nat. Pa		1. Signature of Funeral Service Licensee	hedral Cemetery 11/03/04 22. Name and Address of Facility Ruck To	+ Baltimore, owson Funeral	Maryland Home. Inc.
ä	E E E E		I michael puch	1050 York Road Towsor	ı, Marvland 21	204
			23a. Part 1. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line. Immediate Cause (Final		atory arrest.	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Co NGEST VE Due to (or as a consequence of the consequen			>54RS
	Examiner	_		Antony DISEASE		710425
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury	merli		7 20024
o,	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of	of):		3
8760,	9 4 10	dical	CHRONIC	KIND HAWN		SYR.
Box 6	eath certific attending p for use as	In/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy	23d. Date of d	
	he death the atte	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 1 □ Ves 2 □ No 9 □ Unknown	5 Other (specify)	Month	Day Year
s, P.O.	iaw requires that the di as been signed by the 2 should be detached	by Ph	Part II. Ditier significant conditions continuum to death but not resulting in		e. Did tobacco use contribute	to the cause of death?
ords	v require been sig should b		Cercers Wiscodno Diseris			Probably 4 Unknown
Records,	0 5 0	Completed	1+4 PENTENSION		autopsy prior to performed? death?	
Vital	icien: Th certificate rector, pag	a	25. Was case referred to medical	26. Place of Death (Chec] Yes 252No 1 ☐ Ye k only one)	s 2 No
of V	S S	To B	examiner? 1 Yes 22 No Hospital: 1 Inpatient 2 ER/Out		☐ Residence 6 ☐ Other (Sp	ecify)
on (ling After une	tlon	27. Manner of Death Natural 5 Pending (Month, Day Year) 2 Accident investigation	ime of 28c. Injury at 28d. De 1	scribe how injury occurred	
Division	I or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office 28f. Loc City	eation (Street and Number or F y or Town, State)	Rural Route Number,
	Hospits 4 hours Funere	edical C	29a. Certifier Check only one Medical Examiner: On the basis of examination and and manner stated.	death occurred at the time, date and place, and due do investigation, in my opinion, death occurred at the	to the cause(s) and manner a e time, date and place, and du	as stated. ue to the cause(s)
	To the within 2 To the complei	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mor	nth. Day, Year)
	/		1 Unal Hother	70028812	11 1 0	1
	in		30. Name and address of person who completed cause of death (Item 23a) (inson mo	21204
	Sta Regist		31. Date filed (Month) NOV 90 3- 2004 32. Registar's Signature	B Sparks		

		1 - State Registrar C6	partment of Health and Me ertificate of Death	ental Hygie	ne 2004	34638
Physi /Med		1. Decedent's Name (First, Middle, Last) Charlese T. Hutzel	(2. Date of Death October	30, 2004	3. Time of Death 4:07 a M
Exam	niner	4a. Facility Name (If not institution, give street and number) Gilchrist Center for Hospice Care	4b. City, Town, or Location of Death TOWSON		4c. County of Death Baltimore	
Funera Directo		5. Social Security Number 216-36-0698 Usual Residence of Decedent 6. Sex 1 M 2 T F 65 7. Age (In yrs. last birthday) 6. Sex 7. Age (In yrs. last birthday)	/) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. 0	Date of Birth (Month, Day, Ye ct. 19,	1939 9. Birth	place (State or Foreign cyland
ING Z I Z I 3-UU30 be filed within 72 hours after death with the Maryland tital Hygiene. d other than "natural", or items 23e or 28e-f show event, the Medical Enaminar must be notified at	rector	10a. State	Havre de Grace	10g.	Citizen of What Cou	10d. Inside City Limits 1 Tyes 2 No
ath with	rai D	720 Robinhood Road	21078		United Sta	
USO urs after de al', or Items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give 1 Yes, Give 1 Year or Dates:	. Was Decedent of Hispanic Origin? (Speci If Yes, specify Cuban, Mexican, Puerto Ric 1 ☐ Yes 2 ☑ No Specify:	fy Yes or No- can, etc.)	14. Race - Americ Black, White, Specify:	
Z I Z I 3-UU36 d within 72 hours afi giene. er then "natural", or the Medical Exemi	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of working DO NOT use retired) maker		o. Kind of Business/In	dustry
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baltimore, permit. Pages 1 an Department of Heal Importent: If item 2 any injury or other		20a. Method of Disposition 1	osition (Name of Pattern Place) of Faith Cem. 11/2/		Location - City or To ltimore, N	
Departit. Departit Import	Suce	· auno	Schimunek Funeral H 610 W. MacPhail Roa	d, Bel A		
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ate be executed shysician and the burial-transit	Examiner	Sequentially list conditions, if y, saching to amount of the following cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
physician the buris	dicai	d.				
COLDS, P.O. BOX 08/ wrequires that the death certificate been signed by the attending phys should be detached for use as the	hysician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ery Day Year
wrequires that the been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
The lay	Completed			24a. Was an autopsy performed	prior to cor	psy findings available inpletion of cause of 2 No
OI VITAI IN Physician: The I this certificate har ral director, page	o Be (25. Was case referred to medical examiner? 1 Yes	26. Place of Death (Control 3 ☐ DOA Other: 4 ☐ Nursing Home		a (************************************	
	H	27. Manner of Death 1 Autural 2 Pending 2 Moorth, Day Year) 28b. Time (Month, Day Year) 28b. Time Injury		d. Describe how in	ijury occurred	Hospice
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To the Hospital or Attending Ph within 24 hours effer death, To the Funsral Director: After to completely filled in by the funeral	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Medical Examinar: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred	at the time, date a	and place, and due to	the cause(s)
To wit	4	29b. Signature and title of certifier	29c. License number D 00 51926	0	ctobes 3	
		30. Name and address of person who completed cause of death (Item 23a) (Type Helen M. Gordo			eet	
S Regis	tate strar	31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature	5 Sparks			

4:01am

10/30/04

			for State Registrar	State of Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and I Death	Mental Hyg	iene 2004	34639		
3	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last PAULINE BOOZER 4a. Facility Name (If not institution, give	HELMLY		4b. City, Town, o	r Location of Death	2. Date of Death Month	Day Year 2 2004 4c. County of Dea	3. Time of Death 4:50 A M		
į.	Funeral Director		GENESIS ELDER 5. Social Security Number 417-18-4893 Usual Residence of Decedent		last birthday) Yrs.	SEVERNA If Under 1 Year Months Days		8. Date of Birth (Month, Day, 2 / 8 / 1 9	ANNE AR Year) 9. Bir O 9 SOL	thplace (State or Foreign ountry)		
	h the Maryland or 28a-f show e collined at	irector	10a. State 10b. County MD ANNE AR 10e. Street and Number		y, Town or Lo	10f. Zip Code		10	Og. Citizen of What Co	10d. Inside City Limits 1 Yes 2/1/10		
036	be tiled within 72 hours after death with the Maryland nial Hygiene. dother then "natural", or terms 23e or 28a-f show event. It a Medical Examinat must be undified at	by Funeral Director	8121 PASTURE CO	URT 12. Was Decedent Ever in U. Armed Forces? 1 □ Yes 2 (M) No If Yes, Give Year or Dates:		2114 Vas Decedent of H	lispanic Origin? (S an, Mexican, Puert		J.S.A. 14. Race - Ame Black, Whit	te, etc.		
121215-0036	e filed within 72 hor Il Hygiene. other then "naturi vent, it a Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation 6 <i>completed)</i> College (1-4or 5+)	(Give i	ent's Usual Occup kind of work done of OO NOT use retired	during most of wor	king	FDUCATIO			
Maryland	iges 1 and 2 should be filt of Health and Mental Hy if Item 27 is marked oth or other traumatic event	To Be	17. Father's Name (First, Middle, Last) ELDRIDGE S. BC 19a. Informant's Name/Relationship (T) CECILIA DIANNE	rpe, Print)			MAGGIE and Number or Ru		,	. ,		
Baltimore,	rtmer rtant riant		20a. Method of Disposition 1 \(\text{Disposition} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify)} \) 21. Signature of Fumeral/Service Licens	20b. P	Place of Disposemetery, crem	sition (Name of natory or other place T CEMET	ERY 11/	Date 2	NUBFRRY	Town, State		
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		. 7	Decedent's Name (First, Middle, Last)	007	imoute of E	Journ	2. Date of Death Month						
	Physicia /Medic		John L. Homberg		Oct								
	Examin	er	4a. Facility Name (If not institution, give street and number) Franklin Square Hospital	İ	4b. City, Town, or Location of Death Rosedale			4c. County of Death Baltimore					
	. Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last		If Under 1 Year Months Days		8. Date of Birth	O Piet	nplace (State or Foreign untry)				
L,	Director		212-20-8676 1×1 M 2 F 84 Usual Residence of Decedent	Yrs.	50,0	110010	May23,1	920 Ma	rýland				
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	the Ma 28e-1 s	Director	10e. Street and Number	MI	ddle Ri	ver ———		0%	1 ☐ Yes 2X No				
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036	72 hours after death with the Maryland neturel', or Items 23s or 28e-f show Iteal Examilier must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ② No If Yes, Give Year or Dates:	1f	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 ☑ No	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify hi	e, etc.				
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Maryland	2 should be tand Mental Is marked o	င္	Henry Homberg 19a. Informant's Name/Relationship (Type, Print)	19b Mailin	n Address (Street a		ne Pero	outka ity or Town, State, Z	in Code)				
	alth a		Margaret Homberg / wife					timore 1					
Baltimore,			ceme	etery, crem	sition (Name of latory or other place 11Cemete	ery 11/2		Location - City or 1					
Balt	permit. Page Department of Importent; If any injury or once.		21. Signature of Funeral Service Licensee		Name and Addres	ace Ave.	Baltim	neralHo	meofEssex 21221				
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rds, P	The law requires that the tite has been signed by thoage 2 should be detache	by	by	by	by	by	Part II. Other significant conditions contributing to death but not resulting	g in the un	derlying cause give	n in Part I.		co use contribute to	the cause of death?
Vital Records,		Completed					24a. Was an autopsy performed	prior to o death?	opsy findings available ompletion of cause of				
Vita	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital: Chaptient 2 EQ	/Outpation	Othe	26. Place of Death							
n of	ding Phys h. After this funeral di	\vdash	1 kinpatient 2 EH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)										
Division	Attendir death. ctor: Af y the fu	catlo	2 Accident investigation		M 1 7	es 2□No							
DIV	al or At after d Direct d in by	Certification:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office	2	8t. Location (Stree City or Town, S	t and Number or Rui tate)	al Route Number,				
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	dical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled 2 Madical Examiner: On the basis of examination and manner stated.	dge, death and/or inv	death occurred at the time, date and place, and due to the cause(s) and manner as stated. Wor investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	To the within To the comp	Me	Signature and title of certifier M D		29c. License	number 437	29d.	Date signed (Month)	Day, Year)				
İ	12"		30. Name and address of person who completed cause of death (Item 23 MYO TIHANT SII4 SAND PIPER C	IRCL	E, BAG	cto, no	2123	5					
F	Sta Registr	7	31. Date filed (Month, Day, Year) NOV 3 - 2004 32. gistrar's Signature	, Ago	cell								

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** OBERIA 10 - 04 06:00 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner - 4669 FALIS ROAD BAITIMORE, MANOR CARE BAST, MURE CITY med 7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 07 23 Birthplace (State or Poreign Country) 5. Social Security Number 6. Sex **Funeral** 219-42 9688 Usual Residence of Decedent 1□ M 200 Director death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f show the Medical Examiner must be notified at 1XXes 2 □ No Director MD Baltimore NΑ 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3810 Howard Park Ave 21207 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ★★No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or ital any injury or other traumatic event, the Medical Examinal 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes XIXNo Specify: Specify: Š 3€Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade 17. Father's Name (First, Middle, Last) Laundry Supervisor Marriott Hotel 18. Mother's Name (First, Middle, Maiden Surname) Be Levin Turner Georgia Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 3810 Howard Park Ave, Baltimore, Md 21207 Cynthia A. Perry-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial **ACC** remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 11/1/04 Baltimore, Md 21. Signature of Funeral Service Licensee March F/H West Part. Friter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot of heart failure. List only one cause on each line. 21215 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as e consequence of) Examiner Extremble attending physician and for use as the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): maemie Box 68760. Physician/Medlcal Due to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed the should be detected Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1_ Yes 2ENo 1LIYes 2LING 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: 4 ☐-Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide to critiving Physician: To the best of hy knowledge death control at the time date and place, and due to the causu(s) and maker as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 20a Cortifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27604 tellen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Entano St Fonto 308, Balt MD HASHMI 271 SHOAILS A 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

DHMH 16 Rev 6/95

			for State	State of Maryland	/ Depa	artment of H	ealth and I	Mental Hygi		34642		
			Registrar 1. Decedent's Name (First, Middle, Last)						neg. No.			
П	Physicia	an	1. Decedent's Name (First, Middle, Last)	Ida Mae H	owar	1		Month	Day Year	3. Time of Death		
4	/Medic		4a. Facility Name (If not institution, give str	Owar	4b. City, Town, or	Location of Death		4c. County of Death				
	Examin	ici	SINAL HOIDITAL O				more,		U.S.A.			
	Funeral		5, Social Security Number 6. Sex	tial Security Number 6. Sex 7. Age (In yrs. last birthda				8. Date of Birth (Month, Day,	O Birthologo (Ctata or Foreign			
	Director		220-22-7603	4 2 XX 84	Yrs.	Months Days	Hours Min.	May 3,1	920 Vir	ginia		
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits		
	f sho	ō	Maryland N/A			Baltimo	re			1∭Yes 2 ☐ No		
	28a-	Directo	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	untry?		
	3a ol		1302 Berry Stre	et			21211		USA			
	deat	Funeral		. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (S	pecify Yes or No-	14. Race - Amer Black, White			
9	hours after death with the Maryland tural; or Items 23a or 28a-f show at Examiner must be mullited at		1 Never Married 2 Married	1 ☐ Yes 2x☐tNo If Yes, Give		1 ☐ Yes 201 No		- 1.10411, 0101,		white		
5-0036	be filed within 72 hours after death with the Marylan tae Hygiene. do char than "natural", or items 23a or 28a-f show avent. It a Modeal Examiner in ust be mailled at	ed by	3€XWidowed 4 □ Divorced 15. Decedent's Educa	Year or Dates:	6a Dece	dent's Usual Occupa	ution		16b. Kind of Business/Industry			
5	within 72 ene. than "nai	olete	(Specify only highest grade	completed)	(Give	kind of work done d DO NOT use retired,	luring most of wor	king	OD. KING OF BUSINESSE	noustry		
212	yiene.	Completed	Elementary/Secondary (0·12)	College (1-4or 5+)	Ma	achinist			Black & De	cker Mfgr		
פַ	be filed tal Hyg d otha avent.	Be C	17. Father's Name (First, Middle, Last)				_	ne (First, Middle, M	aiden Sumame)			
Vai		To	Andrew Dinkins				Ja					
Maryland 2121	s 1 and 2 should I Health and Mer Itam 27 la marke othar traumatic		19a. Informant's Name/Relationship (Type Dorothy Hyle Dar			ng Address (Street a Yorkland			City or Town, State, Z MD 21048			
	1 and Health Am 27 thar ti		20a. Method of Disposition						0c. Location - City or 1			
Baltimore,	0 = 5		XX Burial 2 ☐ Cremation 3 ☐ Re			sition (Name of matory or other place w Memoria			Sykesville			
Ξ	그 두 약 극		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License		22	Name and Addres	s of Facility		•			
B	permil Depar Impor any ir once.		Lacered (A)	Dentes	B	irgee-Hens	ss-Seitz	Funeral	Home, Inc.	21211		
			Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21211 23a. Fart. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Open and Poort									
	hysician /Medical Examiner	0 11	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
		_	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (crosses of injury									
	ed isit	Examiner										
	ie be executed ysician and e burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):									
760,	icate be executed physician and s the burial-transil	calE	d.									
		_										
Вох	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 5 ☐ Other (specify)						23d. Date of deli	very Day Year		
Ш	The law requires that the death certifica site has been signed by the atlending ph page 2 should be detached for use as th											
P.O.	that the de led by the a detached f	Phy	Part II. Other significant conditions conti	ib ution to death but not resultin	or in the u	nderlying cause give	en in Part I	23e. Did toba	23e. Did tobacco use contribute to the cause			
ds,	w requires that been signed I should be det	d by	GARTRO INTESTIMA		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown							
Vital Records,	w requ	Completed	24a. Was an 24							4b. Were autopsy findings available		
Вě	The law cate has page 2 t							autopsy perform	prior to completion of cause of death?			
tal	i ician: Th certificate rector, pag	O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2		2 No		
<u> </u>	ysician: Is certific director,	o B	examiner? 1 Yes 2 No	spital: 1 ☐ Inpatient 2 ☑ ER	/Outpatier	nt 3 DOA Othe	or: 4 Nursing H	lome 5 Resider	nce 6 Other (Spec	sity)		
0	문 문 등	Ju: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28	b. Time o Injury		at	28d. Describe how				
Sio	tanding Ph leath. tor: After th the funeral	cath	2 Accident investigation 3 Suicide 6 Could not be				res 2 □No					
Division of	E Sign	Certification;	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, sti	eet, factory, office	t, factory, office 28f. Location (Street and Number or Rural Rou City or Town, State)			ral Houte Number,		
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by		29a. Certifier 1 Certifying Physi	cien: To the best of my knowle	dge, deat	h occurred at the tim	e, date and place	, and due to the car	use(s) and manner as	stated.		
	a Hos 24 h e Fun letely	edical	(Check only 2 Medicel Examine one)	er: On the basis of examination and manner stated.	and/or in	vestigation, in my or	pinion, death occu	rred at the time, da	te and place, and due	to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certifier			29c. License	number		d. Date signed (Month			
)	/		1 /	61529	10-27-04							
	5		30. Name and address of person who con			Print)		> -	141-			
			31. Date filed (Month, Day, Year)	32. Registrar's Signature	IMAI	+ HODINA	01	ofc I IM	,- U			
:	Sta Registi		NOV 0 3 201		B	Spark	1	BACTIM				

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PM 4-06996 onald Hoffman

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item haryland bearings of Health and Mental Hygiene 2004

For State Registrar 34643 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30, **HOFFMAN** October RONALD HARVEY 2004 12:50 A^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12214 Long Lake Drive Owings Mills Baltimore 5. S**2:11 4рон ф Онт 8208** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. JAN. 4,1943 Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Months Days Hours Yrs. 550-37-8732 61 MD Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show ust be notified at 1 ☐ Yes 2 🙀 No Directo MD BALTIMORE OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 12214 LONG LAKE DRIVE 21117 USA itams 23a Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ™ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No WHITE Completed by Specify: 3 Widowed 4 Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 5+PHARMACIST PHARMACY and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HOFFMAN RAE BERGER FRANK ္ရ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a important: If itam 27 is any injury or other trau <u>once</u>. 602 DOUGLAS ROAD - SALISBURY, MD 21801 BARRY HOFFMAN / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARLINGTON CHIZUK AMUNO 11/01/2004 4 DOO ation 5 Other (Specify) BALTIMORE, MD Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscherotic Curdiovasculas **Physician** tty pertensive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 1

Yes 2□No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ★ Other (Specify) SCENE funeral 27. Manner of Death

1 Natural

2 Naccident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To tha Funaral Direct 4 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified O.C.M.E. October 30, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 3 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Marvland / Department of Health and Mental Hygiene

RPD			For State Registrar	State of Maryla		rtment of l		d Mental H	ygiene Reg. N2 0	04	34644	
	Physicia	an	Decedent's Name (First, Middle, Last) Alfonzo			Johnson, Sr.			Death Day	Year	3. Time of Death 0439 P M	
	/Medic Examin		4a. Facility Name (If not institution, give s	30111	4b. City, Town, or Location of Death							
			Johns Hopkins Hosp	oital		Baltimo	re		ı	NA		
	Funeral Director		5. Social Security Number 6. Sex		rs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of B Min. (Month, 1 9-12	irth Day, Year) -46	9. Birthp Coun	place (State or Foreign ntry) Md.	
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loc	cation				1	0d. Inside City Limits	
	Maryi f sho	io	Md. NA		Baltim					'	1 Yes 2 □ No	
	r 28a	rec	10e. Street and Number		Darcin	10f. Zip Code			10g. Citizen of	What Coun	itry?	
	th with	al D	2801 Pelham Ave.			212	13			USA		
	ems	Funeral Director	11. Marital Status	Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Yes, specify Cub	Hispanic Origin	? (Specify Yes or Nuerto Rican, etc.)	lo- 14. Ra	ice - Americ		
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic event, the Mudical Examinat must be multiled at once.	by	1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates:		☐ Yes 21X No			Spec		ack	
5-0	72 hc	Completed	15. Decedent's Educ (Specify only highest grade		16a. Deced	ent's Usual Occu	pation during most of	workina	16b. Kind of I	Business/Ind	dustry	
121	within ne. han	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done OO NOT use retire			City	of Ra	altimore	
2	filed v Hygie ther t int, in		11th grade 17. Father's Name (First, Middle, Last)		Pub	olic Worl	1	Name (First, Middi			TCTROLE	
an	id be ental ked o	To Be	John	F. Jo	hnson					,		
ary	shoul nd M mari	F	19a. Informant's Name/Relationship (Typ			g Address (Stree		othy r Rural Route Num		inson n, State, Zip	Code)	
ž	alth a 2 27 is		Martha Johnson	Wife				Baltimor		21213		
altimore,	ages 1 a nt of He t: If item		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ Re	20b emoval from State	. Place of Dispos cemetery, crem		ice)	Date	20c. Location			
Ē	artme ortani injury		* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License		King Men	Name and Addr		1-4-04				
Ba	Depa Impo any ir		1 & la des	Wane					ore, Md			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
	rnysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):									Onset and Death	
ox 68760,	n certificate be executed inding physician and use as the burial-transit	dlcal	d.	Due to (or as a cons	gnancy				23d. Di	ate of delive	rv	
.O. B	that the death certiff led by the attending detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnanc Other (specify) _	у				Day Year	
Division of Vital Records, P.O. Box	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco							o use contribute to the cause of death?		
al Rec	: The law cate has b page 2 st	Completed						24a. Wa. auto perl 1 🗆 Yes	s an 24b. opsy formed? 2 No	prior to con death?	osy findings available inpletion of cause of 2/100	
× ×	siclan: The certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			200	Death (Check only				
ion of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	1 Inpatient XXEH/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec)	
Divis	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)							Route Number,		
	he Hospil in 24 hour he Funeri	edical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examin	cian: To the best of my ker: On the basis of exami and manner stated.	nowledge, death nation and/or inv	occurred at the ti estigation, in my o	me, date and pl opinion, death o	ace, and due to the ccurred at the time	cause(s) and m , date and place,	anner as sta and due to	ated. the cause(s)	
	To t To t	Z	29b. Signature and title of certifier	1.		29c. Licens	se number		29d. Date signe	ed (Month, D	Jay, Year)	
			Theorem Il	think mus		o.c.	M.E.		October	29, 2	2004	
	(0)		30. Name and address of person who con	npleted seese of death (it	em 23a) (Type, F	rint)					21201	
	Sta		THEOPORE M. EIN 31. Date filed Worth, Cay 72004	Se Registrat's Sig	natura	111 Penn	Street	, Baltimo	ore, Mar	yLand	21201	
	Registra	ar										

State of Maryland / Department of Health and Mental Hygien

		•	1 - State Registrar	Ce	rtificate of	Death	Reg. No.	34645
	4 -		Decedent's Name (First, Middle, Last)			2. Date of	Death	3. Time of Death
	Physici /Medio		Josephine	Jack	son	Octob	er 30, 2004	5736 AM
}	Examir		4a. Facility Name (If not institution, give street and	number)	4b. City, Town, o	r Location of Death	4c. County of Death	
			Union Mem. Hospital			imore	NA	
	Funeral Director		5. Social Security Number 218-05-4287	7. Age (In yrs. last birthday, 92 Yrs.	If Under 1 Year Months Days	Hours Min. (Month,	Birth 9. Birthpla Country 1-12	ce (State or Foreign y) Ga.
	land ow		10a. State 10b. County	10c. City, Town or L	ocation		100	d. Inside City Limits
	Marylan e-f show	to	Md. NA	Balt	imore			X Yes 2 No
	th the	lrec	10e. Street and Number		10f. Zip Code		10g. Citizen of What Countr	y?
	23a	ai	732 Belgian Ave.		21218	3	USA	
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinat must be notified at	by Funeral Director	1 Never Married 2 Married 1 Yes,	lecedent Ever in U.S. 13. Forces? ss 2√ No Give A r Dates:	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※ No	lispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc. Specify:	14. Race - America Black, White, et Specify: Bla	ic.
5-0	72 ho natur tical	Completed	15. Decedent's Education (Specify only highest grade complete	16a. Dece	dent's Usual Occup	ation during most of working	16b. Kind of Business/Indu	stry
2	ithin 7 ne.	nple		e (1-4or 5+)	DO NOT use retired	daring most of working		
	led w lygier her th		8th grade	Lab	orer		Factory Work	er
Maryland	be fi hd ott	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Mid	ldle, Maiden Sumame)	
ž	houid d Mer marke maric	L _O	Henry 19a. Informant's Name/Relationship (Type. Print)	Curry	an Address (Ctross	Rose	Gay	
Ma	d 2 s th an 7 is r traur						mber, City or Town, State, Zip C	000)
á,	Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Ave., Baltimor	20c. Location - City or Tow	n, State
Baltimore,	0 = 0		1 Burial 2 Cremation 3 Removal fro 4 Donation 5 Other (Specify)	Arbutus	matory or other place. Mem. Par	k 11–5–04	Arbutus, Md	•
Bal	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licensee		2. Name and Addre			202
			23a. Part1. Enter the disease, or complications th		March F. F		E. North Ave.	Approximate
	Physician /Medical		shock, or heart failure. List only one cause. Immediate Cause (Final disease or condition resulting in death) a.	n each line. rdiac arr to (or as a consequence of):		g, storr as outdate or respirator	3	nterval Between Onset and Death
	certificate be executed by the certificate be executed by the certificate as the burial-transit but a certificate as the burial-transit but a certificate burial-transit but a certificate burial-transit but a certificate burial-transit but a certificate but a certi	licai Examiner	cause. Enter Underlying that initiated events c.	to (or as a consequence of): to (or as a consequence of):				
ĕ.	death e atter	Physician/Medical	in the past 12 months?		⊒Ectopic pregnancy ⊒ Other (specify)		23d. Date of delivery Month D	ay Year
rds, P	quires that the de n signed by the a uld be detached f	by	Part II. Other significant conditions contributing t	o death but not resulting in the u	inderlying cause give		id tobacco use contribute to the	
al Record	: The law requires that the cate has been signed by th page 2 should be detache	Completed	peripheral vasa	cular dise	use	pi		y findings available eletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:		nt all DOA Oth	26. Place of Death (Check on		
of	Phys r this ral dii	- To	27. Mann of Death 28a. Da	☐ Inpatient 2 ☐ ER/Outpatient 28b. Time of	III SIE DOA	4 Ruising Home 5 H	esidence 6 Other (Specify) be how injury occurred	
Ou	ding P. h. After funer	tol	1 Natural 5 Pending (Natural 2 Accident investigation	lonth, Day Year) Injury	Worl	k? Yes 2 □ No	oo now injury occurred	
Division	or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not be	ace of Injury - At home, farm, st ilding, etc. (Specify)		28f. Locatio	n (Street and Number or Rural F Town, State)	loute Number,
	To the Hospitel or Att within 24 hours after d To the Funerei Direct completely filled in by i	Medical C	(Check only 2 Medical Examiner: On th	the best of my knowledge, deat e basis of examination and/or in anner stated.	h occurred at the timestigation, in my o	ne, date and place, and due to t pinion, death occurred at the tin	he cause(s) and manner as state ne, date and place, and due to the	e cause(s)
)	To th within To the compl	Me	29b. Signature and title of certifier	2. m.D.	29c. Licenso	9 number 54903	29d. Date signed (Month, Da	y, Year)
	1		30. Name and address of person who completed c	ause of death (Item 23a) (Type,	Print)		11/2/04 y, Baltimor	10.4.5
	(V)			lei mo 201	6	rersiry TRW	y, saltimor	e MD
	Sta	ite	NOV 0 3 2004	. Registrar's Signature	O SOO	uls/		

Physic		1. Decedent's Name (First, Middle, La					Mental Hyg		3464
		Suzanne Ar	•	indormon			Month		Year
- /Med Exam		4a. Facility Name (If not institution, giv			4b. City, Town, o	r Location of Death	1	4c. County o	
		941 Lynch Drive			Arno	ld		An	ne Arundel
Funera		5. Social Security Number 6. S	6ex 7. I□M 25√F	Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JAN 3,	Year)	9. Birthplace (State or Foreig Country) New York
Directo	r	093-32-7079 Usual Residence of Decedent	X ZXF	63 Y	rs.		JAN. 3,	1941	New York
iand ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limit:
Mary Fied	ţ	Maryland Anne Ar	undel		Arnold				1 ☐ Yes 2 🛣 No
r 28a	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of WI	hat Country?
th wit		636 Belle Dora	Court		211	71.2		US	A
tems tems	Funeral	11. Marital Status	12. Was Decede Armed Force	% ?	13. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-		- American Indian, , White, etc.
s afte	by Ft	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 24 If Yes, Give		1 ☐ Yes 2 No	Specify:	, , , , , , , , , , , , , , , , , , , ,	Specify:	White
hour tural	ed b	15. Decedent's E	Year or Date		Decedent's Usual Occup	ation		Ob Mind of Dun	:
n "ne	Completed	(Specify only highest gra Elementary/Secondary (0-12)	ade completed)		(Give kind of work done life. DO NOT use retired	during most of work	king	6b. Kind of Bus	iness/industry
d with giene	Eo	12	College (1-4	or 5+) Hi	man Resour	ces		Disabi	lities
be filed within 72 hours after deeth with the Maryland tal Hygiene. d other than "netural", or Items 23e or 28a-f show event. It is Medical Examinating the registed at	Be	17. Father's Name (First, Middle, Last,)				e (First, Middle, M	laiden Sumame)
should but marked	2	Clement Breton				Elma	David		
0 0 0		19a. Informant's Name/Relationship (Mailing Address (Street				tate, Zip Code)
1 and 1ealth 9m 27 ther tr		Andrea E. Senn/da 20a. Method of Disposition	ughter		Cassidy Wa		sbury, PA		
permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr		1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from Sta	110	Disposition (Name of r, crematory or other place	1 11 //	2/04	uc. Location - C	ity or Town, State
it. P.	۵	* 4 □ Donation ** 5 □ Other (Specifical Signature of Funeral Service Liquid		Metro (rematory,	LIIC.		Balti	more, MD
permit. Departr Importa		Primilar	74190pma	ld	22 Name and Addre	Society	of Mary	Land, Ir	nc.
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	McDonald plications that cause	sed the death. Do no	299 Frede	g, such as cardiac	d Baltin or respiratory arre	nore, MI	21228 Approximate
Physiciar		Immediate Cause (Final	one cause on eac	n line.	ial cell c	aucino	MAG		Interval Between Onset and Death
/Medica	_	disease or condition resulting in death)	a. Due to (or	as a consequence of		200000	1		5. Yrs.
Examine:		Sequentially list conditions	b						
D ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or	as a consequence of	ŋ.				
and and I-tran	Examln	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to for	as a consequence of					
cate be executed physicien and the burial-transit	E E		Duo 10 (01	as a consequence of					
o 9 m					n):				
ficat phy s the	edical		d		·):				
n certificat anding phy use as the	a a	IF FEMALE: 23b. Was decedent pregnant	d23c. If yes, outcor	me of pregnancy				23d. Date	of delivery
death certificat ie attending phy ad for use as the	a a	23b. Was decedent pregnant in the past 12 months?	1□Live birth 4□Pregnan	1 2 ☐ Fetal death t at time of death	3 □Ectopic pregnancy 5 □ Other (specify) _			23d. Date Montl	
the death certiff y the attending ched for use as	a a	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 To No 9 Unknown	1 □ Live birth 4 □ Pregnan 9 □ Unknow	a 2 ☐ Fetal death t at time of death	3 ☐ Ectopic pregnancy				
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The law requires that the death certifl ate has been signed by the attending page 2 should be detached for use as	Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the past 12 months? 25. Was case referred to medical examiner?	1 Live birth 4 Pregnan 9 Unknown contributing to deat	a 2 Fetal death t at time of death h but not resulting in	3 □Ectopic pregnancy 5 □ Other (specify) □ the underlying cause giv	en in Part I.	24a. Was an autopsy perform 1 Yes 2	Month acco use contrib c 2 No 3 24b. We prived? de:	nute to the cause of death? Probably 4 Unknown are autopsy findings available for to completion of cause of ath? Yes 2 No
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ding Physiclan: The law requires that the death certifing. After this certificate has been signed by the attending funeral director, page 2 should be detached for use as	To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Part II. Other significant conditions of the examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	Hospital: 28a. Date of I (Month,	at 2 Fetal death that time of death time of death	3 Ectopic pregnancy 5 Other (specify) the underlying cause giv patient 3 DOA Oth me of 28c. Injur Worl	en in Part I. 26. Place of Deat er: 4 Unursing Ho	24a. Was an autopsy perform 1 Yes 2 th (Check only one me 18 Hosider 28d. Describe how	Month acco use contrib cacco use contrib	nute to the cause of death? Probably 4 Unknown are autopsy findings available for to completion of cause of ath? Yes 2 No (Specify Testdence
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or Attanding Physiclan: The law requires that the death certift the death. Iter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	ertification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Hospital: 1 Inp. 28a. Date of 1 (Month, nee 28e. Place of building, niveries and manner.	at time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of the time of tim	3 Ectopic pregnancy 5 Other (specify) the underlying cause giv the underlying cause giv attent 3 DOA Other me of 28c. Injury M 1 mr, street, factory, office	26. Place of Deat 26. Place of Deat 9r: 4 □ Nursing Ho 7 at 7 Yes 2 □ No 1e, date and place, pinion, death occurr	24a. Was an autopsy perform 1 Yes 2 h (Check only one me 28d. Describe how 28f. Location (Street, City or Town, and due to the cated at the time, dat	Month acco use contrib 2 2 No 3 24b. We prive de prive de 1 Control of 1 Control	nute to the cause of death? Probably 4 Unknown are autopsy findings available for to completion of cause of ath? Yes 2 No (Specify Tesidence) or Rural Route Number, her as stated. d due to the cause(s)
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or Attanding Physiclan: The law requires that the death certift the death. Iter death. Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1	Hospital: Base Contributing to death	at time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of death that time of death (Item 23a) (Text time of death (Item 23a)	3 Ectopic pregnancy 5 Other (specify) the underlying cause giv batient 3 DOA Oth me of ury M 28c. Injur Wor M 1 D m, street, factory, office death occurred at the tim for investigation, in my of	26. Place of Deat 26. Place of Deat 9r: 4 □ Nursing Ho 7 at 7 Yes 2 □ No 1e, date and place, pinion, death occurr	24a. Was an autopsy perform 1 Yes 2 h (Check only one me 28d. Describe how 28f. Location (Street, City or Town, and due to the cated at the time, dat	Month acco use contrib 2 2 No 3 24b. We prive de prive de 1 Control of 1 Control	ute to the cause of death? Probably 4 Unknown Breautopsy findings available or to completion of cause of ath? Yes 2 No (Specify Test dence) or Rural Route Number, there as stated, did due to the cause(s)

			For State Registrar	State of N	/laryland / [Depai <i>Cert</i>	rtment of Herificate of E	ealth and Death		giené Reg. No		34647
	Physici	an	1. Decedent's Name (First, Middle, Last)	****					2. Date of De	ath Dav	/ Year	3. Time of Death
	/Medic	al .	Linda G. Keel						Octobe	r 31	, 2004	7:45 AM M
	Examin	er	4a. Facility Name (If not institution, give s 1204 Leonard Drive	treet and numbe	r)		4b. City, Town, or Glen Bur		eath	_	ne Arun	
	Funeral Director		212-44-0373		Age (In yrs. last bii	rthday)_ Yrs.	If Under 1 Year Months Days	If Under 24 H Hours N	Hrs. 8. Date of Bir (Month, Da	th 1 <i>y, Year)</i> 1946	Co	hplace (State or Foreign untry) yland
	land ow		Usual Residence of Decedent 10a, State 10b. County		10c. City, Tow	n or Loc	ation					10d. Inside City Limits
	Mary 1-1 ah	to	Maryland Anne Aru	ndel	Gle	n Bu	ırnie					1 Tes 2 No
	or 282	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Co	untry?
	23a		1204 Leonard Drive				21060			Unit	ed State	es
336	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. itam 27 is marked other then "netural", or Items 23e or 28e-1 ehow other traumatic event, the Medical Event at Incities at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	 Was Deceder Armed Force Yes 2 If Yes, Give Year or Dates 	s? No		as Decedent of His Yes, specify Cubar	spanic Origin? n, Mexican, Pu Specify:	? (Specify Yes or No uerto Rican, etc.))-	14. Race - Ame Black, White Specify: Wh:	e, etc.
Maryland 21215-0036	72 hou	Completed	15. Decedent's Educ (Specify only highest grade		16a	. Decede	ent's Usual Occupa	tion	working	16b. K	ind of Business/	Industry
21	within and the state of the sta	nple	Elementary/Secondary (0-12)	College (1-40	r 5+)	life. D	ind of work done d O NOT use retired)	uning most of	Working			
121	e filed within al Hygiene. other then '		12 17. Father's Name (First, Middle, Last)		Da	ita E	ntry	10 Mathada	Name (First, Middle		dit Bure	eau
and	d be fantal h	o Be	Robert H. Parker						R. Nash	, Maiden	Sumame)	
ary	2 should be and Mental is marked sumatic av	은	19a. Informant's Name/Relationship (Type	oe, Print)	191	o. Mailing			r Rural Route Numb	er, City o	r Town, State, Z	(ip Code)
	alth a		Tammy Daughtry / Da	aughter	37	'07 E	Bay Drive	Baltin	more, Mar	ylan	d 21220	
ore,	of Health of Health item 27 i		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ R	amoual from Ctar	20b. Place o cemete	of Dispos	ition (Name of atory or other place	9)	Date	20c. Lo	ocation - City or	Town, State
Ë	Pag ment ant: h		'4 □Donation 5 □Other (Specify)	anioval from Sta	" Cedar	Hill	. Cemeter	y 11,	/05/2004			
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service Lightse	1. M.	de	401	S. Ches	ter St	reet Balt	imor		al Homes PA land 21231
			23a. Part 1. Enter the disease, or comples shock, or heart failure. List only on	eations that caus e cause on each	ed the death. Do	not ente	r the mode of dying	, such as card	diac or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Pnysician	4 1	Immediate Cause (Final disease or condition resulting in death)	G	adjac		ry tome	as				Oliset and Death
	/Medical Examiner		Tossing in accumy	Due to (or a	as a consequence	of):	Coali		. 14 . 1921			
	44	er	Sequentially list conditions, if any, leading to immediate	. (5) of eud	as a consequence	Oi).	catallo	myopa	aung		V-311	
	cuted nd ransit	Examin	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events						~			
0,	be executed sician and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequence	of):						
8760,	ate hy:	dlcal										
9		0	IF FEMALE:	3c. If yes, outcon	ne of pregnancy					1		
Вох	the death certifi y the attending ached for use as	Physician/M	in the past 12 months?	1 Live birth	2 Fetal death		Ectopic pregnancy Other (specify)				23d. Date of deli Month	very Day Year
0	at the de by the a tached t	hysl	1 ☐ Yes 2 No 9 ☐ Unknown	9□ Unknown								
٥,	es that igned b	by PI	Part II. Other significant conditions con			in the und	derlying cause give	n in Part I.	23e. Did t	obacco u	se contribute to	the cause of death?
rd	w require been sig should b	ted	Ahral	ribyill	allon				_ i>	Yes 2	□No 3□Pro	obably 4 Unknown
Vital Records,	S CA	Completed							24a. Was		24b. Were au	topsy findings available completion of cause of
<u>=</u>		Son							perfo	rmed? 2X No	death?	2□ No
Vita	Phyaician: this certific ral director,	Be	25. Was case referred to medical examiner?	ospital:			Otho	r	Death (Check only o			
of		. To	1 Yes 2 No	1 ☐ Inpa	itient 2 ER/Ou	utpatient Time of		4 🗀 Nursin	ng Home 5 × Resi 28d. Describe			cify)
on	Attanding I ir death. actor: After by the funer	tlor	1 Natural 5 Pending investigation	(Month, E	Jay Year)	Injury	28c. Injury Work M 1 \(\sum Y	? ′es 2 □ No			, 00001100	
Division	Attandi er death. actor: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of	Injury - At home, fa	arm, stre	et, factory, office					ral Route Number.
Ö	tal or rs afte al Dir ed in	Cert	4 CTONICIO	building,	etc. (Specify)				City or To	wii, State	/	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical	29a. Certifier 1 Certifying Physical Check only one) 2 Medicel Examination	icien: To the be ler: On the basis and manner	of examination ar	e, death nd/or inve	occurred at the timestigation, in my op	e, date and pl inion, death o	lace, and due to the occurred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	with To t	Σ	29b. Signature and title of certifier				29c. License		20	29d. Dat	e signed (Month	, Day, Year)
)	/\		ASIL	3	- MD			504		111	1104	
	4		30. Name and address of person who co	UPI,	8109 12	(Type, P	e Hway	; Pa	naderia	MD	21127	2
::	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 3 2004	32. Regi	strar's Signature	4	rock					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrat 34648 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Day Year Physician LLOYD SHIPLEY KEYS, SR. NOVEMBER 1, 2004 0921 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NORTH ARUNDEL HOSPITAL GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 12 M 2 ☐ F 82 Yrs. MARYLAND Director 218-18-3840 7/19/1922 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f ahow Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene. The training a 23e or 28e-1 ahov anit. If item 27 is marked other than "natural", or items 23e or 28e-1 ahov any or other training event, it is by life East and the could be 1 Yes 2 No Completed by Funeral Director BALTIMORE MD PERRY HALL 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 4404 DARLEIGH ROAD 21236 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: WWTT Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 XWidowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SENIOR SUPPORT SPECIALIST I.C. INCORPORATED 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) To Be EMERT KEYS BESSIE MILSTRD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SON 717 MATTAWAW COURT LLOYD S. KEYS, JR. MILLERSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or 11/5/2004 POPLAR GROVE CEMETERY PHOENIX, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signatur of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. the IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed b I be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ 100 24a. Was an 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 길 1 Yes 2 DA/Outpatient 3 □ DOA 2 No 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pendina 1 ☐ Yes 2 ☐ No М death. investigation 2 Accident within 24 hours after death

To tha Funeral Diractor:
completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 112 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1041 J.C. DOWNS MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 001 34649 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Gary Kuyper trober 5-20 PM 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie
If Under 1 Year | If Under 24 Hrs. North Arundel <u>Hospital</u> Anne Arundel 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Funeral 8. Date of Birth (Month, Day, Year) Months 1**⊠**M 2□F Days Hours Yrs. Director 473-44-0683
Usual Residence of Decedent June 14. 1940 Minnesota 64 death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 27 is marked othar than "natural", or items 23a or 28a-f show traumatic event, the Medical Exame and unsation mailtied at 1 ☐ Yes 2 ☑ No Director Anne Arundel Gambrills Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 1036 Christmas Lane Funerai 21054 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 TYes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Completed by Specify: Specify: 3 Widowed 4 Divorced Year or Dates 1958-1961 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry illed withIn and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Technical Supervisor Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental F John Kuiper Evelyn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sl ment of Health and ant: if itam 27 is r <u>Joanne Y. Kuiper/wife</u> 1036 Christmas Lane Department of Healt important: if itam 2 any injury or othar once. othar Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State `4 ☐ Depation 5 ☐ Other (Specify) West Arundel Crematory 11/2/2004 Odenton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Roau Odenton, Maryland 21113 - M00957 Manito nomas 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Metastatic adenocarcinoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? 1 ☐ Yes 2 🗆 No 2 No 1 🗆 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the Director: 6 Could not be 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ь within 24 hours a 29a. Certifier (Check only one)

29b. Signature and title of certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29d. Date signed (Month, Day, Year) October 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W.D 2 Knoll North 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

lai	ne kre.	ιι ie	For State Registrar	State of M	Maryland / D	epartment <i>Certificate</i>	of Hea of De	alth and M eath		gien 2 Reg. No.	004	346	50
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month		Year	3. Time of I	Death
	Physicia /Medic		Stephanie I	Lauren Kre	iner				October		2004	02:20	A^{M}
	Examin		4a. Facility Name (If not institution	, give street and numbe	or)	4b. City, 1	Town, or Lo	cation of Death		4c. C	County of Death		
			8200 Perry Hal				nite M	Marsh Under 24 Hrs.	0 D-1(Dist	\rightarrow	Baltimo		-
	Funeral		5. Social Security Number 216-98-7357	6. Sex 7 1 ☐ M 2 🙀 F	Age (In yrs. last birt 22	hday) If Under Months		Hours Min.	8. Date of Birth (Month, Day Dec. 2,	198	9. Birth	place (State or intry) (Land	Foreign
	Director		Usuel Residence of Decedent						vec. 2,	170	Mary	Rana	
	/land		10a. State 10b. County		10c. City, Town	or Location						10d. Inside Cit	y Limits
	Mary Inc.	ģ	Maryland Baltin	nore		Baltimo	re					1 🗌 Yes	2 N No
	r 28g	Director	10e. Street and Number			10f. Zip	Code			10g. Citize	en of What Cou	intry?	
	th wit		2445 Woodcro	st Road			2	1234		u.	.S.A.		
	ems er m	Funeral	11. Marital Slatus	12. Was Decede Armed Force	nt Ever in U.S. s?	13. Was Decede	ent of Hispa ify Cuban, N	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	. 14	4. Race - Amer Black, White		
36	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Evantinar must be rediffed at	by Fu	1 XNever Married 2 Marr 3 Widowed 4 Divorced	If Yes, Give	•	1 ☐ Yes 2	No S	Specify:		5	Specify:	vhite	
Ş	hour tural		15. Decedent	Year or Date:		Decedent's Usua	LOccupation	n		16h King	d of Business/Ir		
Ċ	in 72	Completed	(Specify only highes	t grade completed)		(Give kind of won life. DO NOT us	k done durir e retired)	ng most of worki	ng	700, 1411	Q 07 203111033/11	idustry	
212	filed with Hygiene. Ither than	mo	Elementary/Secondary (0-12)	College (1-4d	or 5+)	Student	<u>.</u>			Nω	rsing		
힏	m = 0 5	Be C	17. Father's Name (First, Middle,	Last)			18	. Mother's Name	(First, Middle,	Maiden S	Sumame)		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show tumatic event, the Medical Examiner must be indiffed at	10	John Leonard	Kreiner,	IV			Jane F.	rances	Marc	chino		
an)	2 sho and I is me		19a. Informant's Name/Relations			Mailing Address				-		p Code)	
	and ealth m 27		Mr. John Kreine	er, IV (fa	ther) 9	536 Shir	ewood						
o	Pages 1 nent of H int: If ite		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from Sta	10	Disposition (Nam y, crematory or ot		1	Date		ation - City or T		
altimore,	Pag tment tant:		' 4 □ Donation 5 □ Other (S	pecify)	Parkw	ood Ceme	tery	11/3/	2004	Balt	imore,	Maryla	nd
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic es once.		21. Signature of Funeral Selvice	LILEGISCOO)	9705	Belai	of Facility Sch r Rd.,	umunek 1 Baltimo	tuner re, N	ral Home ND 21230	2S 5	
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus only one cause on each	sed the death. Do r	not enter the mode	of dying, s	such as cardiac o	or respiratory arr	rest,		Approximate Interval Betw	veen
	Pnysician		Immediate Cause (Final disease or condition	Moon	pus to	Lyons	5					Onset and D	eath
	/Medical		resulting in death)	u.	as a consequence	Mark Committee of the C							
ii.	Examiner		Sequentially list conditions,	b									
V	is is	ine.	if any, leading to immediate	Due to (or	as a consequence	of):							
	xecut and Il-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a consequence	of):				_	-		
8760,	cate be executed physician and the burial-transit	a E											
687	ficate p physis the	edical		d.									
Box	The law requires that the death certificate be executed; ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	lan/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		۰.۵۰۰				23	3d. Date of deliv	rery	
m	that the death ed by the atte detached for	Cia	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant	2 Fetal death at time of death	3 ☐ Ectopic pre 5 ☐ Other (spe					Month	Day Y	ear
P. 0.	at the d by the tached	Physicia	9 Unknown	9∐ Unknowr	1								
S,	signed of	by F	Part II. Other significant condition	ons contributing to death	n but not resulting in	the underlying ca	ause given ir	n Part I.		,	e contribute to		
ord	w require been si should I	ted							1 🗆 Y	es 2	No 3 □ Pro	bably 4 □Ui	nknown
Record	e law r has be je 2 sh	Completed							24a. Was a autop	sy		opsy findings a	
<u> </u>		Son							1 Yes	med? 2 □ No	death?	2 No	
Vital	sicien: Th certificate irector, pag	Be	25. Was case referred to medical examiner?					6. Place of Death	(Check only or	пе)			
	Physician: this certific ral director,	2	1 X Yes 2 □ No	Hospital: 1 Inpa		tpatient 3 DO		4 Nursing Ho			**	(y) SCI	NE
n C	ding f h. After funer	lon	27. Manner of Death 1 ☐Nétural 5 ☐ Pendin	9 . 0 0 -	Day Year)	njury	3c. Injury at Work? 1 □ Yes	1/6	28d. Describe h			22 (0)01/	100
Division of	Attendi	lcat	2 Accident investig	not be 28e. Place of	Injury - At home, fa				28f. Location (S		Number or Run		
<u>S</u>	after after Dire	Certification:	4 Homicide determ	building,	etc. (Specify)	_			City or Tow	m, State)	LBLVDB		
_	Hospital or Attendin 4 hours after death. Funeral Director: Aft tely filled in by the fur		29a. Certifier 1 ☐ Certifyir	ig Physicien: To the be			at the time, o	date and place,					, w . Fil
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical		Examiner: On the basis and manner	s of examination an								
	To the within 2 To the complet	Me	29b. Signature and title of certifie	1		29c.	. License nu	umber	2	29d. Date	signed (Month,	Day, Year)	
			Molante	The Still	- PW		0.0	C.M.E.		Octo	ber 30,	2004	
	/		30. Name and address of person	who completed cause of	, ,								
	5		MAKYDOND D.	KOREU		111 Penn	Stree	et, Balt	imore,	Mary	land 21	201	
	Sta Regist		31. Date filed (Month, Day, Year)		strar's Signature	b	30 .						
	Regist	ai	NOV 0	3 2004	Geneva	10 13	oore	2/					

State of Maryland / Department of Health and Mental Hygien 1 - For Stete Registrer 34651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Year ANNETTE_COMFORT GLEN KIRSCH /Medical OCT 30 2004 4:37AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death GLEN MEADOWS GLEN ARM BALTIMORE If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 1 □ M 2¥□ F Yrs. 216~44~4965 92 Director Sept. 25.1912 Maryland Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Menial Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic avent, Item Medical Examinating Let notified at anose. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Baltimore County Director 1 ☐ Yes 2XXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 11630 Glen Arm Rd. 21057 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ XXNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes XX No 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Kirsch's Family Elementary/Secondary (0-12) Coilege (1-4or 5+) Self~Employed Restaurant ll yrs. 2 yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ferdinand G. Laux Anna E. Rolle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ann K. Gilbert (Daughter) 5514 Sandy Folly Court Fairfax Station, Va. 22036 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State
1 4 ☐ Donation 5 ☐ Other (Specify) St. John's L. C. Cem. 11-4-2004 Sweet Air, Md. 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Lhorack Approximate Interval Between Onset and Death Farture Immediate Cause (Final Priysician ond disease or condition resulting in death) mani /Medical Due to (or as a consequence of) Examiner (ARDIOMYOPATH) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached 1 □ Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by EMENTIA Completed 1 Yes 2 No 3 Probably 4 Unknown PARKINSONS DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HYPOTHYROIDISM 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attanding Physician: 25. Was case refe red to medical examiner?

1 Tes 2500 Be 26. Place of Death Check onl one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 2 ER/Outpatient 3□ DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation Natural 2 Accident death. 1 ☐ Yes 2 ☐ No within 24 hours after deatl To tha Funaral Diractor: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) LTIMORE MOP ROSS RD ADS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2001 34652 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** James William Korona October 2004 9:52am /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Carroll Hospital Center Westminster Carrol1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Sept 3 1941 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 ☐ F 173-32-8855 PA Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f show Md Carroll Marriottsville 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6918 Pine Hill Court 21104 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. filed within 72 hours atter 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Police senior accountant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fil iment of Health and Mental H lant: If item 27 is marked otl John J. Korona Grace Moriarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karen J. Korona (spouse) 6918 Pine Hill Ct., Marriottsville, Md 21104 20b. Place of Disposition (Name of crematory or other place) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
Crest Lawn Memorial ŏ 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If any injury or once. 11-04-04 Marriottsville, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Daige Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) proumed 1-1410 **Physician** moration /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that interest assets). Due to (or as a consequence of). physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Completed by Physiclan/Medical use as attending for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital To the Hospital or Attanding Physician: tor: After this certific the funeral director, 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ■ R/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours att To the Funaral Di completely tilled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifie 016941 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) poeks 21 (1001)000 / 32. Registrar's Signat State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Darius /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince nder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Southern Maryland 9. Birthplace (State Country) **Funeral** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other then "natural", or Items 23e or 28e-f show ury or other treumetic event, Ite Medical Examinations the notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Elmara Street #4 20032 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1☐ Yes 2☐ No ð Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) None none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lamont Kirkland Damon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town Stephante 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Pagi Depertment Important: If any njury o '4 □Donation 5 🖾 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Baltimore, MD 21201 21. Signature of Funeral Service Licensee ROna of S . Warde 655 W. Baltimore Street 23a. Part \ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): 30 minut Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ed by the attending physician and detached for use as the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 10 23 9 Unknown 04 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' certificate 2 🗆 No 2/2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this After this funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number B 8 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salem 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Darks Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 34654 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24, 2004**Physician** October 4:00 PMM Sarah E. Katzoff /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore 725 Mount Wilson Lane #424 Pikesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2 💢 F 97 Sept 14, 1907 Maryland Director 214-38-3677 Usual Residence of Decedent with the Maryland 10a, State 10c. City. Town or Location 10d, Inside City Limits 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Exercit er mains by molified at MD Baltimore 1√2 Yes 2 1 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 Mt. Wilson Lane #424 death v 21208 USA 14. Race - American Indian, Black, White, etc. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other then "natural", or ite 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 elementary teacher education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Meyer Katzoff Rachel Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 725 Mt. Wilson Lane #424 Baltimore, MD Samuel Katzoff/brother 21208 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages Department of P Important: If ite any njury or ott 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Renald S 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician KS 205 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Muroschohe Curdiavaralar YELES Sequentially list conditions Due to (or as a consequence of). Examiner rrany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

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2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifies Medical one, 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D38675 10/26/04 her MD

DHMH 17 Rev 1/2001

State Registrar #605

BALTIMORE MV 21202

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

301

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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5	Funeral Director		5. Social Security Number 6. Sex 216-12-7857	7. Age (In yrs. Is		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth APR. 9, 1	926	9. Birth	place (State or Foreign
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai C	29a. Certifier (Check only one) 1 Certifying Physicien: 0 Medicel Examiner: On an	To the best of my know the basis of examination displays the manner stated.	ledge, death on and/or inv	occurred at the tim estigation, in my op	e, date and place, a inion, death occurr	and due to the ca ed at the time, da	use(s) and man te and place, ar	ner as sta	ated. the cause(s)
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Vision Attended to death	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury	- At home, farm,		Yes 2 □No	8f. Location (Stree	et and Number or F	Tural Route Number,
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physicien: The law requires that the death certificat within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exami	sician: To the best of r ner: On the basis of ex and manner state	taillillation and/or	ath occurred at the tir investigation, in my o	me, date and place, a opinion, death occurre	nd due to the caused at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	1		29c. Licens	>	29d	. Date signed (Mon	th, Day, Year)
- XI		Chebukoa:	Amupe, r	no	,	50000		11/4	
(0,		30. Name and address of person who co	empleted cause of deal	th (Item 23a) (Typ	e, Print) Klin Sa	hare Pl	VP Ra	Itimore	MD 21237
Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2004	32. Registrar's	Signature	land		1.)

		For State Registrar	State of M	aryland / De	partment of F ertificate of	Health and M	lental Hy	gierze 0 0 4	34657
		1. Decedent's Name (First, I	Middle, Last)				2. Date of De Month	aath Day Yea	3. Time of Death
	sician edical	Ernest	R	•	Lindsay		10	29 2004	
1	miner	4a. Facility Name (If not inst Gilchrist	tution, give street and number) $N \cdot H \cdot$		Towson				imore
Fune Direc		5. Social Security Number 212–22–6469 Usual Residence of Decede	1 X M 2□F	ge (In yrs. last birthda 75 Yrs.	Months Days		8. Date of Bir (Month, Da 2-20-	th ay, Year) -29	Birthplace (State or Foreign Country) Md.
Marylend	tor	10a. State 10b. Co		10c. City, Town or Balt	Location imore				10d. Inside City Limits X☐ Yes 2☐ No
eth with the Marylen 23a or 28e-f ehow	Funeral Director	10e. Street and Number	est Ct.		10f. Zip Code 2123	4		10g. Citizen of What USA	Country?
er der	Fune			No	3. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2√ No	Hispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	14. Race - A Black, W Specify:	merican Indian, hite, etc. Black
215-003 hin 72 hours 	leted	15. Dec (Specify only)	edent's Education nighest grade completed) 12) College (1-4or	5+) (Gi		during most of worki d)	ing	16b. Kind of Busine	
d 212' filed withlr Hyglene. other then	Com	12th grade	B.S. Degre		School Tea			City of E	altimore
Maryland 2 2 should be filed to and Mental Hygle is marked other in the marked other in the marked other in the marked other in the marked other in the marked other in the marked other in the marked	9	17. Father's Name (First, Mi	ddle, Last)	Lindsay	7	18. Mother's Name	(First, Middle	, Maiden Sumame) Spriggs	.
Baltimore, Maryland 21215-0036 permit. Pages 1 end 2 should be filed within 72 hours att Department of Heelih and Mental Hyglene. Importants if them 27 is marked other than "natural; or		19a. Informant's Name/Rela Virginia Li 20a. Method of Disposition		20b. Place of Discemetery, of	Ol Gilchre sposition (Name of crematory or other pla	est Ct., Ba	altimor Date	20c. Location - City	.234 or Town, State
Baltin Permit. Pr Department Important	one minus	21. Signature of Funeral Se		Arbutus	Mem. Par 22. Name and Addre March F.H	ess of Facility	3-04 Balti 1101 E	Arbutus, more, Md. . North Av	21202
by Co. Wedge Examing the between all the principle and the bright princ	cal Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	s a consequence of): s a consequence of): s a consequence of):	disease				Interval Between Onset and Death
Records, P.O. Box 68: The law requires that the deeth certificat	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 □ No 9 □ Unknown) ILLLIVE DIRTI	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) _	y		23d. Date of Month	delivery Day Year
rds, P.	2	Part II. Onler significant co	nditions contributing to death	but not resulting in the	e underlying cause gr	ven in Part I.	23e. Did t	¥.	to the cause of death? Probably 4 □Unknown
Il Record The law requirested has been since the second should be second so the second	v C						24a. Was autor perfo	24b. Were prior death	
on of Vital	Inneral director.	25. Was case referred to mexaminer? 1 Yes 2 No	Hospital:	ient 2 □ ER/Outpa ury 28b. Tim ay Year) Injur	e of 28c. Inju	ry at	n (Check only o	dence 6 VOther (S	pocify) Hospice
Division Division To the Hospitel or Attendit within 24 hours after death.	Certification.	3 Suicide 6 C	could not be etermined 28e. Place of In building, e	njury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,
DIVI DIVI The Hospitel or Al hin 24 hours after the Funerel Direct	Medical Cal	29a. Certifier Ce (Check only 2 Me	rtifying Physician: To the besi dical Examiner: On the basis and manner s	of examination and/or	r investigation, in my	opinion, death occurr		date and place, and o	lue to the cause(s)
To the within	No Som	29b. Signature and title of o	ertifier		DS	88 number 3		OCOS C	
	13	Arran Ci	arson who completed cause of)	To	01 N. Char		reet	
Reg	State gistrar	31. Date filed (Month, Day,	Year) 3 2004 32. Regin	trar's Signature	& spor	Kal			

N		1 = For Unpend Item :	23a, pt. 1	Marylan 1,27,2	d/Depa 8a-Pepa Cea	artment ex me rtificate	t of b	ealth. Death	25 ^d	lental Hyg T as	ien 2 () () 4	34658
		1. Decedent's Name (First, Middle, Las								2. Date of Deat	h		3. Time of Death
Physicia /Medic		Bruce W. Linewe	aver							October	29, 20	Year 004	2045 P M
Examin		4a. Facility Name (If not institution, give	street and num	ber)		4b. City,	Town, or	Location of	of Death		4c. County	of Death	
		Greater Baltimore				Tows					Balti	more	
Funeral		5. Social Security Number 6. So	ex [X]M 2.□F	. Age (In yrs.		If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Jan 19	Year)	Cour	place (State or Foreign ntry)
Director		Unk Usual Residence of Decedent	A		41 Yrs.					Jan. 19,	, 1963	Mary	yland
ms 23a or 28a-f show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
The Health and Menial Hygiene. Items 123 or 28a-f show them 22 or 28a-f show other traumatic event, the Medical Examinet must be notified at	ō	Unk Unk			Unl	7							1 ☐ Yes 2 ☐ No
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ms 2	Completed by Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13.			spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)	14. Rac	e - Americ	
or Ite	2	Never Married 2 Married	1 Tes 2	2 No		ires,spec 1∐ Yes 2		n, mexican Specify:	i, Puerto	nican, etc.)		k, White, تراک	
ra',	d b	3 Widowed 4 Divorced	Year or Dai	tes:		ILI TES A	2121,140	эреспу.			Specify	. Whi	LLE
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han P. Ma	mpi	Elementary/Secondary (0-12)	College (1-	4or 5+)		DO NOT us	e retired,)			C 1		
lygie her t		17. Father's Name (First, Middle, Last)			Labor	rer	-	40 Marks	oda Niasa	Cina Middle A	Const		Lon
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nt of		1 ☐ Burial 2 XX Cremation 3 ☐		tate c	emetery, crei	natory or of	her place	· 1	11/0			•	
ntme njur)	ì	4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service Licen		riet	ro Cre		•			2/04			Maryland
Department of Heal Important: If item 2 any injury or other once.		Thomas Gregor	-		(cremat	ion	Soci	ety.	Of Maryl Baltimo	and In	с.	nd 21228
hysician and projection and more political and was the prijettausit transit.	dical Examiner	shock, or heart failure. List only disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Seizur Due to (o		uence of):								Interval Between Onset and Death
by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions or	4□ Pregna 9□ Unknov	th 2 ☐ Fetal nt at time of down	I death 3 [eath 5 [Ectopic pre Other (spe	ecify)	n in Part I.		23e. Did tob	Mod		ry Day Year
gr be	d by	Complications								1 🗆 Ye	s 2 🗆 No	3 Prob	ably 4 🗀 Unknown
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ate has page 2	E C									autopsy perform	ed?	rior to con leath?	npletion of cause of
certificate rector, pag	e C	25. Was case referred to medical						00 81	-4 D41		□ No 1	Yes	2 No
	00	examiner? 1 X Yes 2 □ No	Hospital:	patient 2 🗆	ER/Outpatien	t 3 □ DO.	Othe		-	Check only one			
After Aune	Certification; To	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Found 10-29-2		Found 4:00	P M	Bc. Injury Work 1 🗆 Y	4 140	No	me 5 Resider 28d. Describe how 28f. Location (Str. City or Town,	w injury occurr eet and Number State) Out	ed er or Rumai	Route Number,
within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one) 1 Certifying Ph	ysician: To the b	sis of examinat	wledge, death tion and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	nd Noble and due to the called at the time, da	use(s) and ma	nner as st	ated.
within 2 To the complet	Me	29b. Signature and title of certifier	S. Za Histille			29c.	License	number		29	d. Date signed	(Month, L	Day, Year)
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of by		30. Name and address of person who of ZMS/4 CCAL	completed cause	of death (Item			Stı	æet,	Bal	timore,	Marylan	nd 21	201
Sta		31. Date filed (Month, Day, Year)		gistrar's Signa	ture 4	10	in V						

State of Maryland / Department of Health and Mental Hygiene 00 [4 34659 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 04:27 M **Physician** Lomsky November Libuse 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Shock Trauma Center City University of Maryland Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7 (Month Bay 3 ear) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Sex **Funeral** Days Months Hours Min. 1 M 2 F Czechoslovakia 81 218-36-2238 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County r than "natural", or items 23a or 28e-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21228 90 Six Notches Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) nd Mental Hygiene. Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event sone. 17. Father's Name (First, Middle, Last) Bozena Hildebrandt Joseph Geisler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 90 Six Notches Ct. Catonsville, MD 21228 Igor Lomsky - Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Z Cremation 3 ☐ Removal from State Baltimore/Weshington Crem. 11/04/2004 Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Home of Catonsville 1630 Edmondson AVe. Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 25 minutes Physician ruptured thoracic aortic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ... LOA OO OU, burial-tran Due to (or as a consequence of): P.O. Box 68760, physicien Physician/Medical the asl attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the 9□ Unknown 9 Unknown þ been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, PV 1 ☐ Yes 2 No 3 Probably 4 Unknown gortic thoracic Completed aneurysm 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 No 25. Was case referred to medical director Be 26 Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Director: After to in by the funeral Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after ō To the Hospitel within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November, 2, 2004 30. Name and address of person who with ed cause of death (Item 23a) (Type, Print) University of Maryland McCurdy MD James 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 03 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2004 34660 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year JOHN GEORGE LUERSSEN /Medical OCT. 30 2004 8:15PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours Min. 212-12-4107 Director 20. 1916 | Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or Itams 23a or 28a-f show the Modical Examiner must be natified at 10d. Inside City Limits Y⊠Yes 2 □ No Directo Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3309 Grenton Avenue 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after VQYes 2 □ No If Yes, Give Year or Dates: WW11 1 Never Married Married 21215-0036 1 ☐ Yes 2 ☐ No 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Mechanic Self-Employed Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be nent of Health and Mental marked Henry Luerssen Marie Lieber and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a Helen E. Luerssen 3309 Grenton Avenue Baltimore, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of Important: If any injury or once. Parkwood Cemetery 11-3-2004 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home Baltimore, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician 1estine Con /Medical Due to (or as a consequence of): **Examiner** S Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examine Due to (or as a consequence of) 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ₩Other (Specify) Hospice filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attanding 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Diractor: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 24 hours a 1 Cretifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1)25205 November 1, 200x ing 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (p. X) 6601 N. Cnarles Street 21204 Towson, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

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			1- For State Registrar	ate of Maryland / Depa <i>Cel</i>	artment of Health ar rtificate of Death		iene 0	04	3466	1
	Physic		Decedent's Name (First, Middle, Last) Kenneth	Stephen	Iona Cm	2. Date of Dea Month		Year	3. Time of Dea	ith
	/Medi Exami		4a. Facility Name (If not institution, give street		4b. CDV) Town or Location of D		4c. County	of Death	12 1	
	Funeral Director	П	5. Social Security Number 215-76-6418 Usual Residence of Decedent	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours	Hrs. 8. Date of Birth (Month, Day, 07 22	Year) 67	Count	ace (State or Fo lry) ID	reign
	yland yland		10a. State 10b. County	10c. City, Town or Lo	ocation			10	d. Inside City Li	mits
	Be-fs	Director	MD NA	Baltimo	ore				X Yes 2□] No
	a or 20	Dire	10e. Street and Number		10f. Zip Code	1	0g. Citizen of V	Vhat Count	ry?	
9	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Menial Hygiene. Item 27 le marked other than "neturel", or Items 23a or 28e-1 show other traumatic event, the Medical Evant at must be collined at	Funeral	4110 Crawford Ave 11. Marital Status 1 □ Never Married 2 ★ Married	as Decedent Ever in U.S. med Forces? ☐ Yes ② No	21215 Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	? (Specify Yes or No- querto Rican, etc.)		e - America k, White, e		
003	urel', o	d by	3 Widowed 4 Divorced Ye	ear of Dates:	1 ☐ Yes XXNo Specify:		Specify	В1	ack	
21215-	in the	Completed	15. Decedent's Education (Specify only highest grade corn	pleted) (Give	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Bu	siness/Ind	ustry	
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	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, Last)			Name (First, Middle, M			VETA	
Maryland	should be nd Mental marked o	2	Wiley Long		Doret	hea Norwo	bod			
Ma	and 2 sho ealth and n 27 le ma		19a. Informant's Name/Relationship (Type, Pr Sonette Long-Wife		Address (Street and Number o					
re,			20a. Method of Disposition	20h Place of Dispo-	Crawford Ave	Date 2	ore, M	City or Tow	1215 m, State	_
imo	mit. Pages hartment of h ortant: If its injury or of		1 ABurial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State Meadow F Memorial	Ridge Park 11	/04/04 I	Elkrid	de.	Мđ	
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee	22	Name and Address of Facility	t		85 - In .		
	0.07 4.0		220 Part Fater to discours as agree lies to	mes 14	1300 Wabash A	ve, Balti	more	Mđ	21215	
	Physician /Medical		23a. Part1. Enter le disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition resulting in death)	se on each line.	or the mode of dying, such as car	diac or respiratory arre	€ Y)		Approximate nterval Between Onset and Death	R
H	Examiner			pue) to (or/as a consequence of): ()	- Empolic	3		-	1	10
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	ecuted and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Marrow (Obesity			- 1	10 year	1
58760,	icate be executed physician and the burial-transit		resulting in deathy cast	Due to (or as a consequence of):						
687		edical	d							
О. Вох	that the death certifi led by the attending I detached for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date Mon	of delivery th D	ay Year	
rds, P	es Deq	by	Part II. Other significant conditions contribution	ng to death but not resulting in the un	derlying cause given in Part I.			bute to the	cause of death?	
Record	as b	plete				24a. Was an	24b. W	ere autops	y findings availal	ble
_	The ate h page	e Completed	25. Was case referred to medical		26 Place of I	autopsy perform 1 Yes 2	ed? de	for to comp	etion of cause of	of
of V	8 w 10	To B	examiner? 1 Yes 2 No Hospita	1 Inpatient 2 ER/Outpatient	Other	g Home 5 ☐ Residen		(Specify)		
	ling L After une	lon:	1 Natural 5 Pending	Date of Injury 28b. Time of Injury Injury	28c. Injury at Work?	28d. Describe how	/ injury occurre	d		
Division	of or Attending after death. I Director: After I in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be 28e	. Place of Injury - At home, farm, stre	M 1 Yes 2 No	28t Location (Street	and and Mounts	0		
	To the Hospitel or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	Il Certification;	4 Homicide	building, etc. (Specify)		28f. Location (Stre City or Town,	State)			
	e Hos 124 ho e Fun letely	edical	(Chock only 2 Medical Califfille). Of	To the best of my knowledge, death the basis of examination and/or inve d manner stated.	occurred at the time, date and pla estigation, in my opinion, death or	ace, and due to the cau ccurred at the time, dat	se(s) and man e and place, ar	ner as state nd due to th	ed. e cause(s)	
	To the within To the comp	Me	29b. Signature and title of certifier		29c. License number	290	1. Date signed	(Month, Da	y, Year)	
)	. \.		1 (Mas	15375	> /	19/2	9/8	8/	
	X		30. Name and address of perion who complete	d cause of death (Item 23a) (Type, P	(rint)	velevre	A. 10.	He	72	
	Sta	te	31. Date filed (Month, Day Year)	32. Regi raf's Signature	III WINI	uccess	Hon	~ >		_
	Registr		MON 0 3 5005	Deneva &	Spark					

			1 - For State Registrar		artment of Health and rtificate of Death		2004 34662
	Physic	ian	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
>	/Medi Examir		Marg 4a. Facility Name (If not institution, give street as		dbetter 4b. City, Town, or Location of Deat		30 2004 05:11 M
			Sinai Hospital		Balto		Ń/A
	Funeral Director		5. Social Security Number 241-62-3798 Usual Residence of Decedent	XF 7. Age (In yrs. last birthday) 65 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthplace (State or Foreign Country) N.C.
	yland		10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	8a-f s	ctor	Md N/A	Balto			1 M Yes 2 □ No
	with the	Dire	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Country?
	death ms 23	eral	2518 Quantico Avenu 11. Marital Status 12. Was		21215 Was Decedent of Hispanic Origin? (S	pecify Yes or No-	U S A
036	iges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If itam 27 is marked other than "natural", or itams 23a or 28a-f show or other traumatic avent, the Medical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 📉 Married 1 ☐	Yes 2 XNo	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 🂢 No Specify:	o Rican, etc.)	Black, White, etc. Specify: Black
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade comple	eted) (Give	dent's Usual Occupation kind of work done during most of wor		b. Kind of Business/Industry
21215-0036	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked othar than "any injury or other traumatic avant, I'lla Me. ODGe.	Completed	Elementary/Secondary (0-12) Colle 12th grade	9ge (1-4or 5+) 5+ Teac	cher]	altimore City Public School
Maryland	ould be fil Mental H arked ott	To Be	17. Father's Name (First, Middle, Last) Elbert Little			ne <i>(First, Middl</i> e, <i>Mai</i> e Hurston	iden Surname)
Mar	nd 2 sho alth and 27 Is ma		19a. Informant's Name/Relationship (<i>Type</i> , <i>Prin</i> Wade Ledbetter, Sr	,	ng Address (Street and Number or Ru Quantico Avenue		
Baltimore,	ages 1 a ent of He- nt; If itam y or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)		sition (Name of natory or other place)		c. Location - City or Town, State
altir	permit. F Departme Importan any injur		21. Signature of Funeral Service Licensee			/2004 Ba March F/H	alto Co, Md West
0	88 28		Synette 1	5 pnes		·	Balto, Md 21215
	Market .		23a. Fart1. Enter the disease, or complications shock, or heard failure. List only one cause Immediate Cause (Final	a to be a			Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Mutastati c e to (or as a consequence of):	. Breast Can	CCR	lyear
	Examiner	<u></u>	Sequentially list conditions, b.	ie to (oi as a consequence of):	tartase S	11	Iyear
	uted d ansit	Examiner	ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Renal for	ilure		1 year
60,	cate be executed physician and the burial-transit	i Exa	rosulting in death) Leat	e to (or as a consequence of))			1 1 0
68760,		edical	d				
.O. Box	at the death certifi by the attending tached for use as	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
<u>α</u>	signed d be de	by	Part II. Other significant conditions contributing	to death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacc	20 use contribute to the cause of death? 2 □ No 3 □ Probably 4 ※Unknown
Records,	s been shoul	ompleted				24a. Was an	24b. Were autopsy findings available
Vital Re	The ate h page	e Com	25. Was case referred to medical			autopsy performed 1 Yes 2 X	prior to completion of cause of
Š	S S S	O B	examiner?	1 ☐ Inpatient 2 ☐ ER/Outpatient	. A Other	th (Check only one)	0 6 ☐Other (Specify)
ion of	ling After fune	ation; T	27. Manner of Death 1 Natural 5 Pending investigation 28a. [Date of Injury Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
Division	i i i te	Certification;	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, stre building, etc. <i>(Specify)</i>	et, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital within 24 hours a To the Funeral C completely filled	edical C	29a. Certifier 1 Certifying Physicien: T 2 Medical Examiner: On t and	o the best of my knowledge, death he basis of examination and/or inv manner stated.	occurred at the time, date and place, estigation, in my opinion, death occur	and due to the cause red at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	1	29c. License number	29d. I	Date signed (Month, Day, Year)
	6	-		eremp	D54413		11/2/04
	9		30. Name and address of person who completed YOUNG J. Lee 31. Date filed (Month, Day, Year)	cause of death (Item 23a) (Type, F 300 (S. Hanov	er St. Balton	ore MD	21225
	Sta Registr		NOV 0 3 2004	A. Hegistrar's Signature	En de		

,1	MTTTEK		State of Maryland / Department of Certificate o		tal Hygien	711111	34663
			Decedent's Name (First, Middle, Last)	2. [Date of Death		3. Time of Death
	Physici /Medic		TROY MILLER	n, or Location of Death		2004 Year	8:34 PM
	Examin	er		MORE CITY		NA	
	Funeral Director		5. Social Security Number 6. Sex 1 AM 2 F 7. Age (In yrs. last birthday) When the property of Decedent for the property of		Date of Birth Month, Day, Year Aw. 7, 19	9. Birthpla Count	ace (State or Foreign ry) UD (
	show		10a. State 10b. County 10c. City, Town or Location			10	d. Inside City Limits
	the Ma	Director	10e. Street and Number 10f. Zip Code	9	10g. C	itizen of What Count	1 Yes 2 □ No
	23a or	al Dir	1602 ST. STEPEN ST. 2	1216		4.5.A.	
36	ter dea Items	by Funeral	1 Never Married 2 Married 1 Yes 2 No	of Hispanic Origin? (Specify uban, Mexican, Puerto Rican No Specify:	Yes or No- n, etc.)	14. Race - America Black, White, e	
90	n 72 hours "naturel", edical En		3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occ	cupation ne during most of working	16b.	Kind of Business/Ind	ustry
Maryland 21215-0036	f within 7 jiene. r then "n	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	UNSOLOR	0	DE Hon	nce
d 2	should be filed with and Mental Hygiene, marked other the umatic event, the	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (Fire	st, Middle, Maide	n Sumame)	
<u> </u>	d 2 should be filed in and Mental Hyg	To	LAMONT E. TAYLOR	VALEPLE eet and Number or Rural Ro	JUI	LLER	Code
	C = r4 r-		19a. Informant's Name/Relationship (Tile, Print) 19b. Mailing Address (Stre 2008 RICHE	- 1 12 1	ACTIMOR	1115	21207
Baltimore.			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other processing to the processing of the processin	Date	1947.0	ocation - City or Tov	
Itim	permit. Pages Department of Importent: If is any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Add	12 10/30/0 dress of Facility	4 HK	VIS, EWEAT	D. STEPPED
Ba	permit. Departrimportri		Tend Cromaitie 2431E.00	LIVER ST. G	ALTO. M	0.121213	ILNUT
			23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of canock, or heart failure. List only one cause on each line. Immediate Cause (Final	lying, such as cardiac or res	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a	Navids			
ı	Examiner	<u>.</u>	Sequentially list conditions, Due to (or as a consequence of):				
W	uted d ansit	Examiner	Tany leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				
60.	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as a consequence of):				
68760		edlcal	d				
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)			23d. Date of deliver Month	y Day Year
_	tuires that the signed by	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		use contribute to the	
Vital Records.		Completed			24a. Was an autopsy performed?	prior to com death?	sy findings available pletion of cause of
Vita	Physicien: Th This certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Ch	The second secon	. 30.1	AT SCENE
		n: To	27. Manuer of Death 28a. Date of Injury (Month. Day Year) 28b. Time of 28c. In (Month. Day Year)	4 Nuising Home	Describe how inju		AT SCENE
Division of	Attending Independent of death. Sector: After by the funer	Certification:	2 Accident investigation U 23 G4 33 CM 1	☐ Yes 2 No		WAS SHOT	Route Number
DİV	el or Al	Sertif	4 Homicide determined determined determined determined determined determined building, etc. (Specify)	86	City or Town, Sta	(e) 1526 WA	YCOUNT
	To the Hospitel or Attendir within 24 hours after death. To the Funerel Director: At completely filled in by the fur	edical C	29a. Certifier (Check only one) 1 ☐ Certifying Physicien: To the best of my knowledge, death occurred at the 2 ☐ Medicel Examiner: On the basis of examination and/or investigation, in mand manner stated.	time, date and place, and o y opinion, death occurred at	due to the cause(s) and manner as sta nd place, and due to	tted. the cause(s)
	To the To the comp	ž		ense number •C•M•E		ate signed (Month, D	,
	2	1				CT. 24, 2	004
_			30. Name and address of person the completed cause of death (Item 23a) (Type, Print) THE MIN TITUS MIN. 1111 Penn Stree	t, Baltimore,	Marylar	nd 21201	
	Sta Regist		NOV 0 3 2004 Sensitive Signature Spaces	,			

State of Maryland / Department of Health and Mental Hygieney 34664 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year 12:45 PM SARA MOYLAN W OCT 28 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T 245-78-3774 Director 56 Sept 7, 1948 Austria Usuel Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28e-f show 10d. Inside City Limits The Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No XX MD Howard Laurel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 8472 Heatherwold Drive 20723-1234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after t ☐ Yes 2 **X Y**o If Yes, Give Year or Dates: 1 Never Married 2XXMarried Maryland 21215-0036 ŏ 1 ☐ Yes 2 🔀 📉 o 2 Specify. Specify: 3 Widowed 4 Divorced White "naturei". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County and Mental Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Middle School Reading Supvr. Public School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental h ဥ James Jackson Watkins Helen Jean Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a Robert R. Moylan, Jr. / spouse 8472 Heatherwold Drive Laurel, Maryland 20723 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Cemetery Nov.1, 2004 Laurel, Maryland 22. Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Avenue Laurel, Maryland 21. Signature of Funeral Service Licensee CASC / M00770 20707 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** BRAIN DEATH Hoves /Medical Due to (or as a consequence of): Examiner MULTISYSTEM ORGAN FAILURE - HEPATIC, RENAL, RESP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed -transit DISSEMINATED INTRAVASCULAR COAGULOPATHY and Due to (or as a consequence of): burial Box 68760. physician Physiclan/Medlcal SPINAL STENDSIS - CSTED ARTHRITIS YEARS the attending use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a Ö 9 Unknown 9 Unknown Δ. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen The law 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Physicien: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nes 2 No Hospital: ۵ 1 Dipatient 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred Attending Division 1 Watural 5 🗌 Pending n 24 hours after death.

he Funerel Director: Aft Injury investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Surcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide ŏ 1 Critifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check unity one) vethin 2 29b. Signature and tille of certifier 29c. License number 29d. Date signed (Month, Day, Year) ひろいりろ ME IND Oct 29, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21042 PATRUCE TOPE MD 1565 Hemlock Line WAY Thicol Δ 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 3 2004 Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 00 L 34665 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year ryden **Physician** Dore 30 AM Mainia October 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catons VIII-Himore harles If Under 1 Year
Months Days 8. Date of Birth (Month, Day, Ye 1-19-1911 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 ☐ M 2 📆 F MD 220-36-6643 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City. Town or Location rat, or items 23a or 28a-f show Examiner must be notified at MD Baltimore Catonsville 1 Yes 2XNo **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 709 Maiden Choice Lane, #N217 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or iter any injury or other traumatic event, the Mivalcal Examination. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No white Specify. Completed by 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Education Elementary/Secondary (0-12) College (1-4or 5+) Principal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Virginia Shockley Putnam Warren Dryden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 506, Wicomico Church, VA 22579 Mrs. Mary Cockrell / niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/4/04 Snow Hill, MD Whatcoat Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Cices ee 22. Name and Address of Facility Singleton Funeral Home P.A. ₩01364 1 Second Ave SW Glen Burnie MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) lerotic Sc Pnysician tthero 1ears /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner DIVISION OF VITAL HECORDS, P.O. Box 68760, — To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. burial-transit and Due to (or as a consequence of) Box 68760, the attending physician ned for use as the buria Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown څ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ģ 3 ☐ Probably 4 ☐ Uniknown 1 Tyes 2 🗌 No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? certificate 2 1 NO 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nersing Home 5 Residence 6 Other (Specify) After this c funeral dire မှ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending within 24 hours after use.

To the Funeral Director: Aft 2 🗌 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type Print) 1 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar NOV 03 2004

State of Maryland / Department of Health and Mental Hygiene 2004 34666 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MALLONE Month 07:40 AM **Physician** EDWARD 26 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Mariner Health at North Arundel Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country)
 MD 6. Sex 7. Age (In yrs. last birthday) 5 Social Security Number **Funeral** Months 1 X M 2 □ F 220-12-8427 78 03/24/1926 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA 709 Wimmer Avenue 21061 death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mentat Hygiene. int: If Item 27 is marked other than "natural", or Ite 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done du life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taxi Driver Cab Company 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Edward Ephriam Mallonee Hilda Amelia Raap 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 709 Wimmer Avenue Glen Burnie, MD 21061 Mrs. Eunice Lomax / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Important: If any injury or once. 10/29/2004 Gwynn Oak, MD Lorraine Park * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral Home 1 Second Ave. SW Glen Burnie, MD Cambere Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine anding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 4 Pregnant at time of death been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an rector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 0 eun 1a 25. Was case referred to medical examiner? Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 🗆 No death. Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) To the 29d. Date signed (Month, Day, Year) 29b. Signatu dalwal 029873 Physician ding 30. Name and address of person who completed cause of death (Item 23a) (Type Print) of S. Crain Hwy # 610 RITA KHANDELNAL, MD 1600 S. Crain Glen Burkie 31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death

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17. Father's Name (First, Middle, Last) JOHN MOYLAN 18. Mother's Name (First, Middle, Last) JOHN MOYLAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200. Place of Disposition (Name of Cember) 201. Method of Disposition 1.05G/rial 2 Oremation 3XX6emoval from State 4 Donation 5 Other (Specify) 21. Signature of Funeral State 4 Donation 5 Other (Specify) 22. Name and Address of Fecility FINK FUNERAL HOME, PA 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 Physician Examiner Physician Examiner 100 289 200 100 100 100 100 100 100 100 100 100	_ c	plet	life, DO NOT use retired)	g	
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30. Name and address of person who completed cause of death (Item 23e) (Type, Print)	38		VATTI. T. ANTHONY 19500 AMN RANTH DRIVE # 13 (ERMANTOWN, MARYLAND	
VATTI. T. ANTHONY 19500 AMMRANTHORIVE # 13 GERMANTOWN, MITTER TO			31. Date filed (Month, Day, Year) 32. Registrar's Signature		

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death State of Maryland / Department of Health and Mental Hygiene 2004 34668	
	Physic	ian	Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death	
	/Medi Examir	cal	Elizabeth Lynn McQuay October 30, 2004 4b. City, Town, or Location of Death 4c. County of Death	
1	Examil	ier	7446 Ricksway Road Milford Mill Baltimore	
	Funeral Director		5. Social Security Number 215-16-1386 6. Sex 1 Months Days Hours Min. Social Security Number 215-16-1386 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Month, Day, Year) Aug. 9, 1947 9. Birthplace (State or Foreign Country) Mary Land	
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits	
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	vith th	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	eath v	eral	7446 Ricksway Road 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	
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lore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or othar traumatic event, Itte Mance.		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Druid Ridge Cemetery or other place)	
Baltimore,	permit. Pages Department of H Important: If ite any injury or ot		21. Signature of Fundami Jarvice Liberisee 22. Name and Address of Facility	
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C	29a. Certifier (Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
)	To th withir To th comp	Me	29b. Signature and title of cartifier 29d. Date signed (Month, Day, Year)	
	5		30. Nane and address of person who completed cause of death (Item 23a) Type, Print: ROLLING (ROST RDS BALTIMORG)	
al. (20)	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature	

State of Maryland / Department of Health and Mental Hygien 34669 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Dylan Quincy McEwen 0647 Oct 26 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** General Hospital Howard County Howard Lane Columbia 5755 Cedan If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 0 Many lan Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic avant, the Medical Examiners ust be notified at Maryland Howard County 1 X Yes 2 No Be Completed by Funeral Director Columbia 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code Thundenhill Road 21045 or Items 23a 5740 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Denise Scott Mc Ewen Mongan Lashune 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) itam 27 5755 CLDAR LANE COLUMBIA, MD. HOWARD COUNTY GENERAL HOSPITAL 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages I Department of H Important: If its any injury or ot 1 Burial 2 Cremation 3 Removal from State Boand 10/26/04 4 ☑ Donation 5 ☐ Other (Specify) Columbia 21. Signature of Funeral Service Licensee Ronald 8. Wade State Anatomy Board 655 W. Baltimore Street baltimore, ND 21201 Direc 23a. Part1. Ever the disease, or conflications that be sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Causa (Final disease or condition Prematunin **Physician** Extreme resulting in death) /Medical Due to (or as a consequence of): Examiner Prenature Labon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of, The law requires that the death certificate be executed Placenta use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Oct. 2004 this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 🗵 No 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Hospital or Attanding After 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Lalon, M.D. MD 18905 76, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ridge Columbia Hickom Road MO 21044 10772

Registrar DHMH 17 Rev 1/2001

State

Date Mad (Would Day (Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

			For 1 State	State of Maryland / Department of He	ealth and Me	ental Hygie	ոջորև	34670
			State Registrar 1. Decedent's Name (First, Middle, L.)	Certificate of Di	eaui	Reg. 2. Date of Death		3. Time of Death
	Physici /Medi		Micha	Murray	(Month CHODER	29, 2004	4:100 M
	Examir		4a. Facility Name (If not institution, gi	ne street and number) NEVALHOSPITAL BALLIMO	nim /11	1/	4c. County of Death	NIA
	Funeral Director				Hours Min.	Date of Birth (Month, Day, Yes	9. Birthp Cour	place (State or Foreign
	within 72 hours efter death with the Maryland ene. than "netural", or items 23a or 28a-f show the Modical Examiner man be notified at	tor	10a. State 10b. County	10c. City, Town or Location 3504 \ F	-con K	lin CJ		0d. Inside City Limits
	efter death with the Marylar or items 23a or 28a-f show ultref rotal be notified at	Funeral Director	10e. Street and Number	10f. Zip Code	Yarı	10g.	Citizen of What Cour	itry?
X	death	nerai	11. Marital Status	12. Was Decedent Ever in U.S. 13. Was Decedent of Hispo	panic Origin? (Speci	ify Yes or No-	14. Race - Americ	an Indian,
386	urs efter al', or ite	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	Armed Eerces? 1 (B) Fes 2 No Army If Yes, Give Year or Dates: 1907 – 1971 1 Yes 2 No 3	Specify:	can, etc.)	Specify:	etc.
70-9	"natur	leted	15. Decedent's E (Specify only highest gi	ducation 16a, Decedent's Usual Occupation	on ring most of working	16b	. Kind of Business/Inc	dustry
212		Completed	Elementary/Secondary (0-12)	College (1-4or 5+) Mechani			Auto	,
land	e d tal	To Be	17. Father's Name (First, Middle, Las		8. Mother's Name (First, Middle, Maid	den Sumame)	1-01-5
Many	and M and M Is mar	-	19a. Informant's Name/Relationship	// 11 1.5 1.5 / //	d Number or Rural I	Route Number, Cit	ry or Town, State, Zip	Code)
T. J.	1 an Heeli em 2 ther	1	20a. Method of Disposition	20b. Place of Disposition (Name of cometery, crematory or other place)	Sreot Dat	e 20c	Location - City or To	wn, Slate
# H	ag ant nt: t	7	1 Burial 2 □ Cremation 3 ['4 □ Donation 5 □ Other (Speci	Corrison Forest	11-4	-040	luings mi	II,MD
Bal	permit. F Departmi importer any injur		21. Signature Fundal Service Lice	22. Name and Address of	or Facility Arch FA	4 and F	whilton Ris	5 BHOMD
			23a. Part Fife the disease, or con shock, or heart failure. List only Immediate Cause (Final	plications that caused the death. Do not enter the mode of dying, sone cause on each line.	such as cardiac or r	espiratory arrest,	,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a son sequence of):	E. Gol	sg-5	15	10/25/04
	Examiner	Je.	Sequentially list conditions,	b. Due to (or as a consequence of):	arlune			10/28/04
	acuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	. Renal Fails	ne			/ /
68760,	icate be executed physician and s the burial-transit	dicai Ex	resulting in death) cast	Due to (or as a consequence of):				
		Medi	IF FEMALE:	20- 1				
. Box	Attending Physicien: The law requires that the death certific rideath. rideath. sctor: After this certificate has been signed by the attending igner the funeral director, page 2 should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (specify)			23d. Date of deliver Month	ry Day Year
P.O.	es that the de igned by the be detached	' Phys	9 ☐ Unknown Part II. Other significant conditions	9☐ Unknown ontributing to death but not resulting in the underlying cause given in	in Part I	23e Did tobacc	o use contribute to the	a cause of death?
Division of Vital Records,	equires tha en signed ould be de	ted by		g and a seco		1 Tes		
Reco	he law require s has been sig ge 2 should b	Completed				24a. Was an autopsy performed?	24b. Were autop prior to corr death?	sy findings available apletion of cause of
İtal	sien: Ti srtificate ctor, pa	Be Co	25. Was case referred to medical examiner?	26	6. Place of Death (C	1□ Yes 2 21		2 🗆 No
of V	Physic this ceral dire	၉	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 28a. Date of Injury 28b. Time of 28c. Injury at			6 □Other (Specify))
ion	ending sath. or: After ne fune	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) Injury Work? I □ Yes	s 2 □ No	d. Describe how in	jury occurred	
=	i or Atte efter de Directo d in by ti	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	Location (Street City or Town, Sta	and Number or Rural ate)	Route Number,
	Hosp 4 hou Fune ely fil	Medical C	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	ysicien: To the best of my knowledge, death occurred at the time, cliner: On the basis of examination and/or investigation, in my opinio and manner stated.	date and place, and on, death occurred	I due to the cause at the time, date a	(s) and manner as sta nd place, and due to	ited. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License nu	umber	29d. C	Date signed (Month, D	ay, Year)
			30. Name and address of person who	completed cause of death (Item 23a) (Type, Print)	8423	L UC	HODOR LY	1,2004
/~ "	-		Shaii Nair	MD, Clo Mary land (10ne	eral Ho	Spita		
()	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 3 2004	32. Registrar's Signature		1		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ctober 2004 JEANETTE MANNS /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death City, Town, or Location of Death Examiner Baltimore pital Marylana General N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (În yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M **X**(X)F 56 NORTH CAROLINA Director 1948 215-46-8380 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Works ! 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f sho other treumatic event, it a Maritial Exercit at must be confilled at 1XXYes 2 ☐ No Directo MARYLAND N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5327 CORDELIA AVENUE 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: BLACK 3 ☐ Widowed 4X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other treumatic even" Elementary/Secondary (0-12) College (1-4or 5+) 10th grade SEAMTRESS CHARITIES APP. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) CRAWFORD ALLEN JANIE WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William A Manns/Ex-husband 6045 Arizona Ave., Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1XXSurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MEADOWVIEW CEMETERY 11-02-04 OXFORD, NORTH CAROLINA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. allace 1206 W NORTH AVENUE 234 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed burial-transit and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 📆 No 9 Unknown 9 Unknown The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 4 Unknown 1 Yes 2 No 3 Probably Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy 1 Yes 2 X No of Vital director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Hospital: ٩ 1 🗌 Yes 2 ER/Outpatient 3 DOA hours after death.

Ineral Director: After this y filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending Natural 2 Accident 5 Pending investigation М 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 0 within 24 hours a Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical the 29b. Signature and title of certifier 29c. License number 0 30. Name a address of per or mpleted cause of death (Item 23a) (Type, Print) General Hospital Komia, Go Maryland M.D. 31. Date filed (Month, Day, Year) NOV 0 3 32. Fegistrar's Signature State Registrar

Box 68760,

P.O.

Records,

Division

State of Maryland / Department of Health and Mental Hygieney 34672 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Gilbert Martin October 29, 2004 /Medical 8:56 am 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ESSEX
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 527 Franklin Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) 10/17/1915 **Funeral** Birthplece (State or Foreign Country) 1**X**0 M 2□ F Director 214-03-7640 89 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinating Interpolitied at 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 527 Franklin Avenue S. S. A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Yas Giva 3 Widowed 4 □ Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Heating 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) d 2 should be finand Mental His marked ott Be Thomas Frank Martin Anna Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If Item 27 lg <u> Elaine Gilner (Daughter)</u> 529 Franklin Avenue Essex, Maryland 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 11/1 2004 injury or 4 ☐ Donation 5 ☐ Other (Specify) Meadow Ridge Memorial Park Elkridge, Maryland permit. 21. Signa of fjuneral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Ess. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Parn. Enter the distance, or heart failu Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death MYOCARDIAL INFARCTION **Physician** O MINUTES /Medical **Examiner** CARDINASCULAR DISPASE YPERTERSIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): 68760 Physician/Medical as IF FFMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) <u>о</u>. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an autopsy performed? certificate Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Hospital or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours at To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PARGAMENT, M.D JEFFREY M. PHILAPERATA RD BALTO, MD 21237 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 For State Registrar 34673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARGARET MOEBUIS NORMAN November 2004 8:09P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4 Upland Road, Apt #39 Baltimore City N/AIf Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔂 F 84 Director 212-12-4370 Dec 9, 1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examinat must be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ⊋Yes 2 □ No Director Maryland N/ABaltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4 Upland Road, Apt #39 21210 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: 3 T√Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Postal Claims Inspector US Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Moebuis ဂ္ Rose Unknown IInknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathlyn M. Davison (Cousin) 4 Upland Road, Apt 17, Baltimore, Maryland 21210 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ▼Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 11/3/2004 Baltimore, Maryland Green Mount Cemetery 21. Signature of Funeral Service Libers 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Martin D. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximation. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner nerosclaro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ettending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 1 No 2□ No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 No Other: 4 Nursing Home Certification: To 1 Yes 5 Residence 6 ☐ Other (Specify) 27. Manyler of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifiet Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Davis McConnell, M.D., 6301 North Charles Street, Suite 5, Baltimore, D 31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signatur State

DHMH 17 Rev 1/2001

Registrar

			Please Type or	Print in Black	Indelible Ink. Ensure	e All Copies A	re Legible.
			1 - State C Registrar	of Maryland / D	epartment of Health ar Certificate of Death		en2004 34674
	Physici /Medic Examir Funeral	al	1. Decedent's Name (First, Middle, Last) Imagen M. Newlin 4a. Facility Name (If not institution, give street and not social Security Number 6. Sex	Age (In yrs. last birth	4b. City, Town, or Location of December 24 Color	ore City	4c. County of Death N/A
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland of Mental Hygiene. In marked other then "neturel", or Items 23a or 28a-f show be umatic event, the Medical Eva cher must be notified at		To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland N/A 10e. Street and Number 4202 Maine Ave. 11. Marital Status 1 Never Married 2 Marned 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade 17. Father's Name (First, Middle, Last) Charles Gill 19a. Informant's Name/Relationship (Type, Print) Ruth Kuhn (Sister) 20a. Method of Disposition	10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town 10c. City, Town	or Location Baltimore 10f. Zip Code 21207 13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 Yes 2 No Specify: Decedent's Usual Occupation Give kind of work done during most of life. DO NOT use retired) Medical Secretar 18. Mother's Mailing Address (Street and Number of	10g 17 (Specify Yes or No- Puerto Rican, etc.) 18 19 19 19 19 10 10 10 10 10 10 10 10 10 10 10 10 10	10d. Inside City Limits 1 Yes 2 No 3. Citizen of What Country? U. S. A. 14. Race · American Indian, Black, White, etc. Specify: White 3b. Kind of Business/Industry Doctor's Office Liden Sumame)
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny Injury or other tre once.		1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify Maus 0). 21. Signature of Funeral Service Licensee	eum Druid	Ridge Mausoleum 1 22. Name and Address of Facility 3331 Brehms Lane	Schimunek F 2, Baltimore	e, Maryland 21213
	And the provided of the provid	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	caused the death. Do no asach line. (or as a consequence of (or as a conseque	disease prin		Interval Between Onset and Death
.O. Box	0 0	Physician/Medica	in the past 12 months?	tcome of pregnancy birth 2 Fetal death nant at time of death own	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
Records, P.	requires been sigr should be	Completed by Pł	Part II. Other significant conditions contributing to d				
Division of Vital	or Attending Physicien: The lava after delate. after delate, the sentificate has a fin by the funeral director, page 2 d in by the funeral director, page 2.	Certification; To Be C	27. Manner of Death 1 Natural 5 Pending investigation 2 Accident of Could not be determined determined	of Injury - At home, farning, etc. (Specify)	atient 3 DOA Other: 4 Nursin N	Death Check onl one ng Home 5 Residence 28d. Describe how	injury occurred at and Number or Rural Route Number,
	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical C	one) 2 Medical Examiner: On the b	e best of my knowledge, asis of examination and/ ner stated.	death occurred at the time, date and p or investigation, in my opinion, death o	occurred at the time, date	and place, and due to the cause(s)
	To with To cor	~	Trace.	7. D.	29c. License number		Date signed (Month, Day, Year) Lober 23,2004

State Registrar books

DR · Kompt inverse 2401

31. Date filed (Month, Day, Year)

1. 3V 0 3 2004

32. Registrals Signature

			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of H			iene 0	04	346	75
	Physic		1. Decedent's Name (First, Middle, DEBORAH	Last)	1	NICKLAS		2. Date of Death Month OCTOBER	Day	Year 2004	3. Time of D	
	/Medic Examir		4a. Facility Name (If not institution, THE JOHNS HOPK		AL	4b. City, Town, o	r Location of Death	ITY	4c. Cour	nty of Death		
	Funeral Director		5. Social Security Number 213–50–0255 Usual Residence of Decedent	6. Sex 7. Age 1 ☐ M 2 X F	(In yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 05/26/19	Year)	9. Birthp Coun Mary	lace (Ŝtate or F itry)	Foreign
death with the Maryland	ous arier deam with the maryland rai', or Itams 23a or 28a-1 show Experimer must be notified at	i Director	MD Ball 10e. Street and Number	timore	10c. City, Town or Lo	10f. Zip Code		10		of What Coun	0d. Inside City 1 ☐ Yes 2 stry?	
0036	al', or Ita	ed by Funerai	13524 Bottom 1 11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Ex Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates:		21082 Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Span, Mexican, Puerto Specify:		Spec	ace - Americ lack, White,	etc. Ce	
C1717	within 72 ho gione. In than "natur Ine Medical	Completed	(Specify only highest Elementary/Secondary (0-12) 12	grade completed) College (1-4or 5+	(Give	kind of work done of DO NOT use retired	during most of work d)	ing		al Do	ĺ	
yland ,	Mental Hygarked other	To Be C	17. Father's Name (First, Middle, L	?			18. Mother's Name	a (First, Middle, N				
e, mary	i and z should Health and Mer am 27 is marke ther traumatic		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard W. NTcklas (husband) 13524 Bottom Road - Hydes, Maryland 21082 20a. Method of Disposition (Name of Committee) 20b. Place of Disposition (Name of Committee) 20c. Location - City or Town, State of Committee (Name of Committee)									
Baitimor	permit. Fages Department of Important: If it any injury or o		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L	ecify)	Fork U.M.	Church C	1	04/2004 F. Lassa	Fork, thn Fu	Maryl meral	land Home,	P.A. 087
	hysician /Medical Examiner		23a. Part1. Enter the disease, or of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	nly one cause on each line 1+EPA Due to (or as a	he death. Do not ent TIC FAIL consequence of):	er the mode of dyin	ng, such as cardiac o	or respiratory arre	st,		Approximate Interval Betwee Onset and Dec	en eath
00,	be executed cian and burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. CHOLAN	ARTERY CONSEQUENCE OF STREET OF STRE		I INTO HE	EPATIC J	EJUNU		1 DAY	H-S
ָ כָ	ine death ceiting y the attending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,			Pate of deliver	ry Day Yea	ar
cords, P	s been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								ntribute to the cause of death?	
I Rec	ate has b	Completed						24a. Was an autopsy perform		prior to com death?	osy findings ava apletion of caus	ailable se of
Of VICAL Physiclan:	this	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of Injury (Month, Day	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 2 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work?					(Check only one) ie 5 ☐ Residence 6 ☐ Other (Specify) Bd. Describe how injury occurred		
UNISION	in the numbers of Attentions within 24 hours after death. To the Eunard Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of Injun- building, etc.	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,		nber or Rural	Route Number	r,
1	the nospi	edicai	one) 2 Medical E	Physician: To the best of xaminer: On the basis of e and manner state	xamination and/or inv	estigation, in my or	pinion, death occurre	ed at the time, dat	e and place	, and due to	the cause(s)	
F	ToT	M	29b. Signature and title of certifier	for		29c. License	- 000			ed (Month, D		
	15		30. Name and address of person w		eth (Item 23a) (Type,	Print)	ET, BALT				-9106	6
t	Sta Registr	ate	31. Date filed (Month, Day, Year)	32. Registrar	s Signature	Spork	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygie 2 1 1 4

21.676

			1 - For State Registrar	State of Mai		Certificate of	Death	Reg. f		34010
	Physicia	n	1. Decedent's Name (First, Middle, Last,		1 - 0	0		0.1.10.11		3. Time of Death
	/Medic	al	ADLAIDE	JOYA	VER	PAYNO	<u> </u>	CT. 3		4 12:20AM
	Examin	er	4a. Facility Name (If not institution, give	street and number) RBOR MEM	HASOIT		or Location of Death	~ -	4c. County of Dea HARFO	
	Funeral		5. Social Security Number 6. Sec	x 7. Age	(In yrs last birti		r If Under 24 Hrs. 8. Hours Min.	Date of Birth	9. Bir	rthplace (State or Foreign ountry)
	Director		237-38-0826 1L Usual Residence of Decedent]м 2ДГ	Da.	rs. World's Days	FINAL F	Date of Birth Month, Day, Yea EB, OZ, I	922 NO	RTH CAROLINA
	yland now		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Ū	e Mar	ctor	MARYLAND CEC	214		COL	ORA			1 ☐ Yes 2 ☑ No
3	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "neturel", or Items 23a or 28e-f ehow svent, I've Medical Evarution in must be rectified at	Directo	10e. Street and Number	T - 1/ A	0/-	10f. Zip Code	21011	10g. (Citizen of What Co	,
4	ns 23	Funerai		TOSH DI		13. Was Decedent of	Hispanic Origin? (Specify	Yes or No-	14. Race - Ame	
2 0	after or iter	풀	1 ☐ Never Married 2 △ Married	Armed Forces? 1 ☐ Yes 2 🙉 No		If Yes, specify Cut 1 ☐ Yes 2 △ No	Hispanic Origin? (Specify ban, Mexican, Puerto Rican) Specify:	in, etc.)	Black, Whit	
A D 5-0036	"neturel",	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:					Specify:	LACK
15-	in 72 n "net	Completed	15. Decedent's Edu (Specify only highest grade	e completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of working ed)	16b.	Kind of Business	Andustry
13) 22	d with giene. er the	E O	Elementary/Secondary (0-12)	College (1-4or 5+))	SEAL		Co	NTINENT	TAL CAN CO.
	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)	:./	T (18. Mother's Name (Fit		1.1	
A YW Maryland	should be filed within and Mental Hygiene. I marked other then umatic svent, I'm M	ပ	KEV. ARDRO 19a. Informant's Name/Relationship (Ty			VER	1) ERTH t and Number or Rural Ro		HARL	
	nd 2 sulth an 27 is r treu		VELMA EILIS	(SISTE		OI HUNTING		-		5.NC27870
Baltimore	of Hor	1	20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ R		20b. Place of cemetery	Disposition (Name of r, crematory or other pla	Date	20c.	Location - City or	Town, State
Ĕ	Pa ment: ury		'4 □Donation 5 □ Other (Specify)		CROWN	SVILLE CEME	TERY 11-04	-04 CK	COUNS VI	WE MP.
Bal	permit. Departn Importe any inju		21. Signature of Funeral Service License	1/11) 11	1.	22. Name and Addr	ess of Facility BROW	NJR.F		HOME
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ications that caused th	he death. Do no	ot enter the mode of dy	ing, such as cardiac or res	piratory arrest,	,10, MD.	21217 Approximate
	Physician		shock, or heart failure. List only or immediate Cause (Final disease or condition	lacause on each line.	alled 1	leodtum.	Kou Cat	Citte.	sto.	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence o		David Go	vaca	SI NO	
504		7	Sequentially list conditions,	Due to (or as a	consequence o	n.				
Ø =	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		3011004461100	.,.				
ó	an and		resulting in death) Last	Due to (or as a o	consequence of	f):				
68760,	tificate be executed g physician and as the burial-transit	Medicai		l		,				
	ear Ise		IF FEMALE:	3c. If yes, outcome of	pregnancy				23d. Date of deli	ivan
. Box	ires that the death cer signed by the attendir I be detached for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1□Live birth 2 4□Pregnant at tin	Fetal death	3 □Ectopic pregnand 5 □ Other (specify) _	ey .		Month Month	Day Year
P.0	at the d by th etache	Phys	9 □Unknown	9□ Unknown						
S,	signed	ρ	Part II. Other significant conditions con	itributing to death but	not resulting in	the underlying cause gr	ven in Part I.	23e. Did tobacco		the cause of death?
S C -	w require been sig should b	ietec	Theumoria	/2000000	200-110	W 12 00 71		24a. Was an		
S &	The lavate has	Completed	C. C. J. M. C.	Dia Die	101.0	1105 11 1	560,60	autopsy performed?	prior to death?	stopsy findings available completion of cause of
) /	icien: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?	WOMO	New	r smisell	26. Place of Death (Ch	1 ☐ Yes 2 ☐ N eck only one	o I Tes	2□ No
2 to	Phyeic this co	ို	1 ☐ Yes 2 No ☐ H	lospital: 1 Inpatient	-	Datient 3 DOA			6 □Other (Spec	olfy)
	ding th. th. After funer	tion	Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Y	Ye <i>ar)</i> 28b. Ti	ury Wo	ryat irk?]Yes 2 □No	Describe how inj	ury occurred	
Division	Attendra dear dear ector.	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (y - At home, farr	m, street, factory, office	28f. L	ocation (Street a	and Number or Ru	ıral Route Number,
Ö	itel or Ins afte rel Dir lled in									
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifica completely filled in by the funeral director.	edicai	29a. Certifier Certifying Physics (Check only one) 2 Medicel Examin	sicien: To the best of r ner: On the basis of ea and manner state	xamination and	death occurred at the ti for investigation, in my	me, date and place, and copinion, death occurred at	lue to the cause(the time, date ar	s) and manner as nd place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	1/ /		29c. Licens	se number	29d. D	ate signed (Month	n, Day, Year)
	1		+ Harry Ju	NOM		D	37564	00	toble	30, 200.4
	C		30. Name and address of secon who co	mpleted cause o deal	th (Item 23a) (T	xpe, Print)	MIN	yano		
	Stat	е	31. Date filed (Month, Day, Year)	32. Registrar's	s Signature	Ja Carello	7	1		
	Registra	ır	NOV 0 3 2004	Morene	N. A	herei				

			1 - For State of Registrar	Maryland / Depa	artment of Heartificate of De		ental Hygie	/ 1114	34677
ľ	Physici		Decedent's Name (First, Middle, Last) Elizabeth		Palmer		2. Date of Death Month 10-31-2	Day Year	3. Time of Death 1:25a M
	/Medic Examin		4a. Facility Name (If not institution, give street and number Future Care N.H. Homewo		4b. City, Town, or Loc Balt	imore		4c. County of Death	<u></u>
79.	Funeral Director		5. Social Security Number 213-30-2451 Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye 12–21–33	iar) Coun	lace (State or Foreign ltry) Md.
	with the Maryland c or 28a-1 ahow be notified at	Funeral Director	MG. NA 10e. Street and Number	10c. City, Town or Lo	cation ltimore 10f. Zip Code 212	017	10g.	Citizen of What Coun	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Itam 27 is marked other than "natural", or itams 23s or 28s-1 ahow other traumatic avent. It a Medical Evantiner must be redified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Noivorced 12. Was Decec Armed Force 1 Noivorced 15 Noivorced 15 Noivorced 15 Noivorced	dent Ever in U.S. 13. 13. 13. 13. 13. 14. 15. 15. 15. 15. 15. 15. 15. 15. 15. 15	Was Decedent of Hispa f Yes, specify Cuban, N □ Yes 🛣 No S	nnic Origin? (Spec Mexican, Puerto R Specify:	16b	14. Race - Americ Black, White, Specify: B1a	etc. ack
2	filed within 72 Hygiene. other then "ne ant, the Media	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-8th grade	life.	kind of work done during DO NOT use retired) Presser		g (First, Middle, Maid	Jos. Bank	S
Maryland	2 should be fil and Mental H is marked oft sumatic avan	To Be	17. Father's Name (First, Middle, Last) John Cor	nish		Elizak	oeth	Johns	
Baltimore, Mary			19a. Informant's Name/Relationship (Type, Print) Aaron Long Cousin 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	20b. Place of Dispo	ng Address (Street and 5 Healy Far usition (Name of matory or other place) unt Cem.		Baltimore		228 own, State
Balti	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee		Name and Address of March F.H.			ore, Md. North Ave.	21202
8760,	The law requires that the death certificate be executed as the has been signed by the attending physician and upper large 2 should be detached for use as the buriat-transit	dical Examiner	shock, or heart failure. List only one cause on ear Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (conditions)	or as a consequence of): or as a consequence of): (as a consequence of):	Cam	cer sint s	Lisea	se	Inferval Between Onset and Death
O. Box 6	that the death certifica ed by the attending ph detached for use as ti	Physician/Med	23b. Was decedent pregnant 1 Live bir	ant at time of death 5	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
rds, P.	w requires that the been signed by should be detact	by	Part II. Other significant conditions contributing to dea	ath but not resulting in the u	nderlying cause given in	n Part I.	23e. Did tobacc	co use contribute to th 2 □ No 3 □ Prob	
Il Records,	iù 🗀	Completed					24a. Was an autopsy performed 1 Yes 2 1	l? death?	psy findings available inpletion of cause of 2 No
f Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes	patient 2 ER/Outpatier	Other	 Place of Death Wursing Hom 		e 6 ☐Other (Specify	y)
Division of	After fune	Certification:	27. Manner of Death 1 SNatural 5 Pending investigation 3 Suicide 6 Could not be determined 28a. Date or (Month) 28a. Date or (Month) 28a. Place of building	f Injury , Day Year) 28b. Time o Injury of Injury - At home, farm, str g, etc. (Specify)	Work? M 1 ☐ Yes	2 No	8d. Describe how in 8f. Location (Streen City or Town, St	t and Number or Rura	l Route Number,
	To the Hospitel or Attene within 24 hours after death To the Funeral Director; completely filled in by the	edical Ce	29a. Certifier (Check only one) Check only one) Certifying Physician: To the ba and mann	sis of examination and/or in	h occurred at the time, ovestigation, in my opinio	date and place, ar on, death occurre	nd due to the cause d at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	Toth within Toth Comp	Me	29b. Signature and title of certifier 30. Name and address of person who completed cause	e of deat Hern 23a) Type,	29c. License nu	umber 1421 C All	29d.	Date signed (Month,	Day, Year)
	Sta Regist		31. Date filed (Man 12 Pay 0 3 2004 32. P	egistrar's Signature	Sparks	/	Terror I) - (-94)

			For State Registrar	State of Maryla		artment of rtificate of			giene Reg. NO	104	34678
	Physicia	an.	Decedent's Name (First, Middle, Last)					2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	John Joseph Perk			4b City Town	or Location of Death	Novem		2004 nty of Death	449AM
	Examin	er	4a. Facility Name (If not institution, give s	(Inchital	intor	40. City, 10Wii,	20 da la		B	Alti N	1060
	Funeral		5. Social Security Number 6. Sex		s. last birthday)	If Under Yea Months Days		8. Date of Birt (Month, Da June I	th v Year)	Cour	place (State or Foreign
	Director		214-30-0473	M 2□F	64 Yrs.	Inchars Day	J Hours IVIII.	June T	5, 1940	0 Mar	ÿ1and
	and aw		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	ocation				1	0d. Inside City Limits
	Maryl -f sho	tor	Maryland Baltimor	e	Middle	River					1 ☐ Yes 2 X No
	h the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	of What Cour	ntry?
	23a c	alD	742 Maple Crest Dr			21220			USA		
	tems	unel	11. Maritar Status	12. Was Decedent Ever in Armed Forces?	.960 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp Jban, Mexican, Puerto	ecify Yes or No Rican, etc.)		ace - Americ lack, White,	
36	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28e-f show fra M. Jical Examiner , ust be notified at	Completed by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	IM 1185 21 1NO	964	1 ☐ Yes 2 🔀 No	o Specify:		Spec	cify: Whi	te
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occi	upation ne during most of work	ina	16b. Kind of	Business/In	dustry
215	ithin 7 e. ien "n	nple	(Specify only highest grade	College (1-4or 5+)	life.	DO NOT use retir	red)	,,,,	A to o		T d
	filed wi Hygien other th		17. Father's Name (First, Middle, Last)		1	aborer	18. Mother's Nam	e (First Middle			Industry
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than eumatic event, the M) Be	Kenneth R. Perkin	S				Evelyn (uo,	
Z	should and Men marke	1º	19a. Informant's Name/Relationship (Ty		19b. Maili	ng Address (Stree	et and Number or Run			m, State, Zip	Code)
	and 2 ealth a n 27 is		Mary Evelyn Perkin	s / Mother	742 M	aple Cre	est Drive				
ore,	of Health of Health (i	20a. Method of Disposition 1 Burial 20 Cremation 3 R	Removal from State	cemetery, cre	osition (Name of matory or other p	lace)	Date	20c. Location	•	
Ĭ	Pages Iment of I Ient: If it		* 4 ☐ Donation 5 ☐ Other (Specify)	Me		matory]		2/04	Baltin	nore,	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23e or 28e-f show amy injury or other treumatic event, the Madical Extraction rough the notified at ORCs.		21. Signature of Funeral Service License Themas Gregor		2		n Society (erick Road			nc. arylan	
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the de ne cause on each line.	eath. Do not en	ter the mode of dy	. 1	0	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	DISSEMIC	ated	Intrai	Vascular	Coac	gulati	00	
	Examiner			Due to (or as a cons	equence of):				J		
Ш		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying								
	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events	c							
760,	te be executed ysician and te burial-transif	I Ex	resulting in death) Last	Due to (or as a cons	equence of):						
6876	cate b physic the b	dical		d							
9 XC	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant 2	23c. If yes, outcome of pre-					23d. l	Date of delive	ery
Box	death e atter d for u	Iclar	in the past 12 months?	1☐Live birth 2☐F		⊒Ectopic pregnan ⊒ Other <i>(specify)</i>			'	Month	Day Year
P.0	at the by the	hys	9 Unknown	9□ Unknown				se Pitt			
	ν ⊆ φ		Part II. Other significant conditions con	ntributing to death but not	resulting in the i	inderlying cause o	given in Part I.	1 🗆 `	-		he cause of death?
ord	w require s been sig	eted						24a. Was			psy findings available
Records,	The law sete has b page 2 s	Completed						autop perfo	osy rmed?	prior to co death?	mpletion of cause of
Vital		e Co	25. Was case referred to medical				26. Place of Deat	1 ☐ Yes	2 No	1 🗆 Yes	2□ No
>	d is	To B	eyaminer?	Hospital: 1 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA)thon	ome 5 Resid		Other (Specif	y)
n of	ding Phye h. After this funeral di		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time (W		28d. Describe I	now injury occ	urred	
Siol	Attending or death.	catle	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No	OOA Lanation (Chan and a sent Alice		/ Courte Alvenhar
Division	or Att	Certification:	4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t nome, tarm, si ecify)	reet, factory, offic	:8	City or Tox		inder of Aute	al Route Number,
ш	spitel	a C		sician: To the best of my l							
	he Ho in 24 t he Fu pleteiy	edical	one)	ner: On the basis of exam and manner stated.	ination and/or in						
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1111		29c. Lice	onse number		29d. Date sign	ned (Month,	Day, Year)
			- Wassin E	K-HIGH	tom 20=1 CT	Print)	01451		Novem	16er/	2004
	HX,		20. Name and address of person who co	ompleted cause of death (I	tem 23a) (Type	nKlin S	quarell	iveRi	2Hi	More	MD 2/23:
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature	,		, -0	+ '-		1
	Regist	rar	NOV 0 3 200	14 Denera	1	Spark	2				

State of Maryland / Department of Health and Mental Hygien 2001 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12.55PM OCT 28 MARL 2004 PAIGE /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner OWSON GENESTS NURSING If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 M 20 F 077-22-497 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County e filed within 72 hours efter death with the Marylen al Hygiene. I other then "neturel", or liems 23e or 28e-f ehow vent, the Medical Exeminar mast be notified at BALTIMORE 1 Pres 2 No Director 10e. Street and Number 10g. Citizen of What Country? 1604 454 WOD 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cubas, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK Specify: 2 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DD NDT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) ACTIMORE ITTY GOVT 18, Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mentel Hiant: If Item 27 is marked off Be TORDAN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/239 MD 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 11-03-04 BALTIMORE, MO ZZON CEM. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HOWELL Funeral Service License 4600 LIBERTY HEHRS Part : Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imin dote Cause (Final discusse or condition resulting in death) DAYS Priysician DIABETES MELLITU /Medical Due to (or as a consequence of) Examiner NYPERTENSION DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner settending physicien end for use es the buriel-trensit CEREBROUASCULAR death cartificete be executed ACCIDENT Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the eld be deteched for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? icete hes been signer. . pege 2 should be d Division of Vital Records, ð 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificate has 1 🗌 Yes 2 No el or Attanding Physician: T s efter deeth. il Director: After this certificat od in by the funerel director, ps 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mappier of Death 28b. Time of Injury 28d. Describe how injury occurred Certification; Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a
To the Funerel C
completely filled I Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005315 unte M.D NOV 154 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO 30 X C174 14D 21042 CUPTA SHAWNMAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 3 2004

State of Maryland / Department of Health and Mental Hygiens 34680 For State Registra Certificate of Death Rea. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** KENNETH 10:22 AM 0 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TOH APPLICABLE MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Yrs Director MARYLAND 110-16-3225 80 4/28/1924 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Exp. illust mast ke notified at MD N/A Baltimore City 1 ▼ Yes 2 No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 6100 EVERALL COURT APT. 104 21206 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: WHITE Specify: Completed by 3 Widowed 4 Divorced TATATO 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) BUTCHER GIANT 12TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be KENNETH PUHL MARY MARGARET KNOTT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE, HILARY CHRISTIAN MD DAUGHTER 2525 GUILFORD AVE. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST VET. 11/4/2004 4 ☐ Donation 5 ☐ Other (Specify) Owing Mills, Md 22. Na LEMS TER A Facility THE JOHNSON FUNERAL HOME, P.A. of Funeral Service Licenses 21. Signature 8521 LOCH RAVEN BLVD. TOWSON. MD Paul. Enter the disease, or complications that cause, the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one couse on each ine. Interval Between Onset and Death SHOCK Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence Examiner SQUAMOUS CELL CARCINOMA Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 2 🗆 No detached 9 Unknown 9 Unknown ģ signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 2 No 3 Probably 4 Unknown acute should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has filled in by the funeral director, page 2 autopsy certificate or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient Certification: To 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death 2 Accident hours after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a B Funeral I 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6435A KUSAKABE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1X1 237 WEST STREET, BALTIMO WD 21217 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 3 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 004 34681 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month -**Physician** 1017 M 2004 Nona Iris Potts /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Deeth Examiner (2) m orth VS No ter mali Burnie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Director 212-22-2280 78 Oct. 21, MD 1926 Usual Residence of Decedent with the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "naturel", or items 23a or 28e-f shov treumatic event, the Medical Examinating the notified at 1 Yes 2 No MD Glen Burnie Anne Arundel Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 113 Buckingham Drive 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or Item any injury or other treumatic event, the Market or Once. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1☐ Yes 2☐ No Specify: 3 Widowed 4 Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) August Lehnert Mary Adler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Joseph Potts / husband 113 Buckingham Drive, Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 14 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD Loudon Park Cemetery Nov 1,2004 21. Signature of Punchal Sympactic Insee 22. Name and Address of Facility Singleton Funeral Home P.A. 1 Second Avenue S.W., Glen Burnie, MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cancer Physician /Medical Due to (or as a consequence of : Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transit Due to (or as a consequence of): been signed by the attending physician should be detached for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1° Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dat of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 ∏No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospitel within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes 1 - For Stete Registrar 34682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Edgar J. Petty Nov.2, 2004 6:00a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner Manor Care Rossville Rosedale Baltimore 8. Date of Birth (Month, Day, Year) 7 1923 MAryland If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X**1M 2∏ F 81 Director 216-12-6039 Usual Residence of Decedent 10c. City Town or Location 10a State 10b County 10d. Inside City Limits item 27 is marked other than "neturel", or items 23s or 28a-f show other treumetic event, the Modical Examinar must be notified at MD Baltimore Essex 1 ☐ Yes 🗶 🗓 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1711 Turkey Point Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 25 Married Baltimore, Maryland 21215-0036 *swih*aite If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Comp Elementary/Secondary (0-12) College (1-4or 5+) Cottman Co. Hygiene. Longshoreman 12 shoutd be filed w h and Menta! Hygier 7 Is marked other th 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ellsworth Petty Agnes Moon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s of Health an Leoba M. Petty / wife 1711 Turkey Point Road Balto.MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages 1 Deportment of H Importent: If ite any injury or ot HollyHillCemetery 11/4/04 1

Burial 2 □ Cremation 3 □ Removal from State Baltimore MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility ConnellyFuneralHomeofEssex 300 Mace Ave. Baltimore MD 21221
of enter the mode of dying, such as cardiac or respiratory arrest,
Approxim 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one ions that caused the death. Do Approximate Interval Between Onset and Death Immediate Cause (Final Priysician HEARS ONGESTIVE disease or condition resulting in death) /Medical a consequence of) Examiner oscles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as the burial-transit and Due to (or as a consequence of): attending physician Box 68760 certificate be Physician/Medical IF FEMALE: 950 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown signed by t Id be detach not resulting in the underlying cause given in Part I. Part II. Other significant conditions contributing to death by 23e. Did tobacco use contribute to the cause of death? Records. þ 06struct Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 \ No 1 Yes 1 TYAS Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: No P 1 🗌 Yes Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred Hospital or Attending Pl
 Abours after death.
 Funeral Director: After the Certification: Injury at Work? Injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of Name and address Eastern Blod., sex Registrar's Signature 2004 Registrar

			1 - For State of Maryland / Department	artment of Health and Mertificate of Death		ene g. no. 2004 34683
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Eula Y. Peice		2. Date of Death Month	29 2004 10:05 AM
}	Examin		4a. Facility Name (If not institution, give street and number) Northwest Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Ray day Stay If Under 1 Year If Under 24 Hrs.	Jn.	4c. County of Death Battino Re
	Funeral Director		249-80-2148 Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, 10–09–192)	9. Birthplace (State or Foreign County) South Carolina
	Maryland -f show	tor	10a. State 10b. County 10c. City, Town or Low MD NA Baltimor			10d. Inside City Limits 1 Ayes 2 □ No
	3a or 28a	il Direc	10e. Street and Number 3135 Ripple Road	10f. Zip Code 21244	10	g. Citizen of What Country? USA
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any follury or other traumatic event, if a Micdical Erai in artificial at once.	by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto R	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	d within 72 ho giene. rr than "natur If a Medicul	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) ood Service	g	6b. Kind of Business/Industry
Maryland	uld be file Mental Hyg irked othe	To Be C	17. Father's Name (First, Middle, Last) Choner Young	18. Mother's Name	(First, Middle, Miertha Wal	
	and 2 sho salth and P 127 la me er traume		07 44 55 55	ng Address (Street and Number or Rural Greco Garth Columbia,	Route Number,	City or Town, State, Zîp Code)
Baltimore,	Pages 1.		A punar 2 Centration 3 Hemoval from State	sition (Name of natory or other place) morial Gardens 11-04-(oc. Location - City or Town, State Chester, South Carolina
Balt	permit. Departr Imports any inju		21. Signature of Funeral Service Incensee 22	2. Name and Address of Facility 1ie Funeral Home 638 N.		
68760,	ificate be exacuted /Medical Examiner and physician and street in the purial-transit	edical Examiner	23a Pant. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only operations that caused the death. Do not enter shock or heart failure. List only operations that caused the death. Do not enter shock or heart failure. List only operations on each line. Due to (or is a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	er the mode of dying, such as cardiac or Inflorm malay epherel value revolution	Low	Approximate Interval Batween nset and Death Author Grant
P.O. Box	The law requires that the death certifical that bean signed by the attending ploage 2 should be detached for use as in	Completed by Physician/Med		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P	w requires that s bean signed b s should be deta	ted by PI	Part II. Other significant conditions contributing to death but not resulting in the un Lomplete heart block, Die	nderlying cause given in Part I. Gheth Mellitry	23e. Did toba	cco use contribute to the cause of death? 2 No 3 Probably 4 Unknown
tal Rec	Physician: The law in this certificate has board director, page 2 sh	Φ	25. Was case referred to medical	26. Place of Death		24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
Division of Vital Records,	ttending death. ctor: Afte / the fune	Certification: To B	examiner? 1 Yes 2 No	Other: 4 Nursing Home 28c. Injury at Work? M 1 Yes 2 No	e 5 ☐ Residene 3d. Describe how	et and Number or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	edicai	29a. Certifler (Check only one) 1 Certifying Physicien: To the best of my knowledge, death 2 Medicel Examiner: On the basis of examination and/or invariant and manner stated.	occurred at the time, date and place, an restigation, in my opinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as stated. o and place, and due to the cause(s)
,	Tot Com	M	29b. Signature and title of certifier Daufman Mo	29c. License number D 54 288	290	Determined (Month, Day, Ygar) October 2575 2004.
)_	18/		30 Name and address of person who completed suse of death (Item 23a) (Type,)	Print) Mortly west Ho	spital	Deto signed (Month, Day, 19an) October 25 2004,
	Sta Registr		31. Date filed (Month, Day, Ned) 2004 32. Registrar's Signature	sparks		

			For State Registrar	State of N	Maryland	d / Depa <i>Cei</i>	artment of tificate o	Health	and M	lental Hyg	giene Reg. No.	004	346	84
	Dhusia		Decedent's Name (First, Middle,	Last)						2. Date of Dea Month	ath		3. Time o	f Death
	Physici /Medi		Margaret	Н.		Phil	lips			Octobe	r 30	2004	3:00	а м
	Examir	ner	4a. Facility Name (If not institution,		*		4b. City, Town	, or Locatio	n of Death		4c. C	ounty of Death		
			1119 Indian La 5. Social Security Number		Age (In yrs. Ia		Mille If Under 1 Ye		le er 24 Hrs.			ne Arur		
ı	Funeral Director		212–32–3023	1 M 2 M F	96	Yrs.	Months Day			8. Date of Birth (Month, Day	r, Year)	9. Birth	place (State ontry)	or Foreign
	70		Usual Residence of Decedent							June 8	, 190	o Mary	land	
	nylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation			-			0d. Inside C	ity Limits
	8a-f s	cto		Arundel	Mi	illers	ville						1 🗆 Yes	2 💢 No
	with th	E E	10e. Street and Number				10f. Zip Code				10g. Citize	n of What Coul	ntry?	
	eath is 23	Funeral Director	1119 Indian Lan	12. Was Deceden	t Ever in 11 S	10.1		1108	2-1-2-10-10-	77.14		SA		
·0	fter d	Ē	1 □ Never Married 2 □ Marrie	Armed Forces	s?	3. 13. V	Yes, specify C	uban, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show its Medical Examinar must be notified at	by	3 \ Widowed 4 □ Divorced	If Yes, Give Year or Dates		1	☐ Yes 2 X	lo <i>Speci</i> i	fy:		Sp	pecify: B	1ack	
2-0	72 hc	Completed	15. Decedent's (Specify only highest	Education		16a. Deced	ent's Usual Occ kind of work do	cupation	net of worki	200	16b. Kind	of Business/In	dustry	
2	vithin ne. han "	mpi	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	O NOT use ret	ired)	ost or worki	ng				
5	iled v Hygie thar t		17. Father's Name (First, Middle, La	ast)		Homema	aker	40.14-4	h _ d _ h 1	(P** - > 0.0**/-#		Home		
and	d be antal	o Be	Thomas Hall, Sr							(First, Middle,		mame)		
Maryland	shoul nd Me mari	2	19a. Informant's Name/Relationship		-	19b. Mailin	a Address (Stre			Chapma I Route Number		nwa State Zin	Code	
	alth a alth a 27 la		Julia H. Freema	n (Sister)						ad, Mil				08
altimore,	of He of He litam		20a. Method of Disposition			ce of Dispos	sition (Name of atory or other p					ion - City or To		
Ĕ	Page ment ant: It ury o		XXBurial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		9	_	Cemet		11/3/	2004	Anna	olis,	MD	
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a or 28a-f show any injury or othar traumatic evant, the Medical Examinat must be notified at ance.		21. Signature of Funeral Service L	pensee		22.	Name and Add			Home P.				
	0 □ = e 0						12 Rids	gely A	venue	, Annap	olis,	MD 21	401	
ı			23a. Part1. Enter the disease, or conshock, or heart failure. List or	ity one cause on each	ine.	Do not ente	r the mode of d	ying, such a	is cardiac o	r respiratory arr	est,		Approximate Interval Bets Onset and D	ween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a Jeffe	·							1	week	4
	Examiner			Due to (or a	s a conseque	ence of):								•
		Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (of a	a conseque	ence of):	/							
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	c										
Ő,	icate be executed physician and s the burial-transit	i Ex	resulting in death) Last	Due to (or a	s a conseque	ence of):						ì		
8760,	cate b	dicai		d										
× 6	eath certific attending p	a)	IF FEMALE:	23c. If yes, outcome	e of pregnan	CV								
Вох	death atter	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal c	leath 3	Ectopic pregnan Other (specify)	су			23d.	Date of delive Month		'ear
o.	that the de led by the a detached f	hysi	1 ☐ Yes 2 MNo 9 ☐ Unknown	9□ Unknown										
S, D	The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	by P	Part II. Other significant conditions	s contributing to death	but not result	ting in the un	derlying cause g	rven in Part	l.	23e. Did tob	acco use	contribute to th	e cause of de	eath?
ğ	w require been significant	ted	Dementra	-				·		1 🗆 Ye	s 2 N	o 3 🗆 Proba	ably 4 □U	nknown
Record	ne law n has be ge 2 sh	Completed								24a. Was ar		4b. Were autop	sy findings a	ivailable
		Con								perform	ned?	death?	2 ∑ No	830 01
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				AL		(Check only one			/	
o	Phys this ral dii	70	1 ☐ Yes 2 No 27. Manner of Death	1 ☐ Inpati	-	R/Outpatient 8b. Time of	3 □ DOA 28c. Inj			e 5 ⊀ Reside 8d. Describe ho)	
Division	Attending In death. actor: After by the funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Month, Da	ay Year)	Injury	W	ork? ∐Yes 2.[od. Describe no	w injury oc	curred		
<u> S</u>	Attendi rr death actor: A by the fu	ifica	3 Suicide 6 Could not 4 Homicide determine	ad 286. Place of in	ijury - At hom	e, farm, stre				8f. Location (Str	eet and No	umber or Rural	Route Numb	er.
	tal or	Certification;	4 - Normolde	building, e	tc. (Specify)					City or Town	, State)			
	To tha Hospital or Attenc within 24 hours after death To tha Funaral Diractor: completely filled in by the i	edical	(Check only 2 Medical Ex	Physician: To the best	t of my knowl	edge, death	occurred at the	time, date a	nd place, at	nd due to the ca	use(s) and	manner as sta	ited.	
	tha h	Med	7-1	and manner s	tated.									
	7 × 10 0		29b. Signature and title of oertific	A -	~		29c. Licer	ise number	*C	29	d. Date sig	gned (Month, D	Pay, Year)	
	10	1	30 Name and address of an	N/	O dooth //	12a\ (T: :: -	1) 3	845	1		4/	1 /4		
	ψ		30. Name a st address of pels n wh	o completed cause of	ueath (Item 2	(Type, P	nnt)	. 6	-1	# me	and	1 + 10	2 2111	>
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	rar's Signatui	re ,	nyon	10	24	100	Ulle	WOU P	11211)
	Registra	ar	NOV 0 3 200	14 Com	رسد	B ,	Joans	/						

State of Maryland / Department of Health and Mental Hygien 2004 34685 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Year Phipps VOU Blanche Eleanor 330 M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1223 Linton Lane Shady Side Anne Arundel If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year Dec. 5, 19 9. Birthplace (State or Foreign **Funeral** Months 1 ☐ M 2 💢 F Director 217-16-1965 93 1910 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itams 23a or 28e-f show other traumatic event. The Medical Examiner must be notified at 1 ☐ Yes 2 X No Directo Anne Arundel Shady Side 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1223 Linton Lane 20764 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 shoutd be filed within 7 h and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Clerk State of Maryland 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Linton Virginia Cora Parks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is n eny injury or other traum William C. Phipps (Son) 1223 Linton Lane, Shady Side, MD 20764 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodfield Cemetery 11-5-2004 Galesville, MD 21. Signature of Funevel Service Consee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** evioscleratio disease or condition resulting in death) /Medical Due to (or as a Examiner tes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. attending physician Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day 4☐Pregnant at time of death 5 Other (specify) P.O. the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes 2000 1 TYAS of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred After t Certification: Division Hospitei or Attending 5 Pending investigation Injury 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident s after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier vmt cause of death (Item 23a) (Type, Print) oaks 31. Date filed (Month, Day, NOV 0 3 2004 32. Registrar's Signature State Registrar

			For State	State of Ma	ryland / Dep	partment of Fertificate of	Health and M	lental Hygi	en200	4 34686
			Registrar 1. Decedent's Name (First, Middle, La			Timcate of	Dealli	2. Date of Death	g. No.	3. Time of Death
	Physici /Medic		MIRACLE	MARIE	PARKE	R		Month	13 20	ear A ENO O
	Examir Funeral		4a. Facility Name (If not institution, given the control of the co	nd Medica	cal Center	4b. City, Town, o	MOVE CI	8. Date of Birth	4c. County of	Death Birthplace (State or Foreign
	Director		218-96-7604	I□М Ж ДГ	Yrs.	Months Days 04 10	Hours Min.	(Month, Day, 06 13		MD
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	e Mar Sa-fel	Director	MD NA		Baltimo	re				X XYes 2 □ No
	with the		10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	at Country?
	death ms 23	era	2503 Seamon Ave	12. Was Decedent E	ver in U.S. 13.	. Was Decedent of H	225 Iispanic Origin? (Spe	cify Yes or No.	U.S	• A • American Indian,
21215-0036	d within 72 hours after death with the Maryland piene. r then "naturel", or Items 23e or 28e-1 ehow the Madical Examiner must be natified at	by Funeral	Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	Armed Forces? 1 Yes Yes Year or Dates:		If Yes, specify Cuba 1 ☐ Yes XXNo	an, Mexican, Puerto I Specify:	Rican, etc.)	Black,	White, etc. Black
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212	d within jiene. r then "	omp	Elementary/Secondary (0-12)	College (1-4or 5-	·) /// // // // // // // // // // // // /	N/A	3)		27 / 2	
nd	be filed tal Hygi d other event, I	Bec	17. Father's Name (First, Middle, Last,			N/A	18. Mother's Name	(First, Middle, M.	aiden Sumame)	
Maryland	should be nd Mental marked c	2	Richard Parker				Tierra	Butler		
Ma	d 2 s th ar th ar trau		19a. Informant's Name/Relationship (MARKETER		and Number or Rura			te, Zip Code)
ře,			Tierra Butler- 20a. Method of Disposition		20b. Place of Disp	Seamon osition (Name of ematory or other place	Ave, Bal		Md Dc. Location - Cit	21225 y or Town, State
altimore,	Pag nent ant: I ury o		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif		1		·	30/04 R	andall	stown, Md
Balt	permit. Pag Department Important: I any injury o		21. Signituri of Funeral Service Licer	1selb	2	2. Name and Address arch F/H	ss of Facility	, , ,		ocowin, ma
	402 6 0		23a. Part . Enter the disease, or com	plications that caused t	4	300 Waba	sh Ave.	Baltim	ore, M	
	Physician		Immediate Cause (Final	one cause on each line	0	1	g, such as cardiac or	respiratory arres	it,	Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	nale				
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68760,	ficate be executed physician and s the burial-transit	edicai		d						
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Вох	that the death certified by the attending detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 4 Pregnant at ti	Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of Month	delivery Day Year
P.O.	at the c by the	hys	9 Unknown	9□ Unknown						
	ires tha signed I	ρ	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	inderlying cause give	en in Part I.		. /	e to the cause of death?
Soro	w requir been s should	eted						1 Tes	2 ∀ No 3 □	Probably 4 Unknown
Vital Records,	he lav e has age 2	ompleted						24a. Was an autopsy performe	prior	autopsy findings available to completion of cause of
ta		e C	25. Was case referred to medical				26. Place of Death]No 1 1 1	′es 2. No
	Physic this ce al direc	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Impatient	2 ER/Outpatier	nt 3 DOA Othe	or: 4 ☐ Nursing Hom		ce 6 Other (S	Specify)
o uc	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injury Work	at 28	3d. Describe how	înjury occurred	
Division of	or Attending Physician: after death. Director: After this certification by the funeral director.	ficat	2 Accident investigation 3 Suicide 6 Could not be 4 Demoiside determined		y - At home, farm, str		es 2 □No	I ocation (Stree	at and Number of	Rural Route Number,
É	2 # # E	Certification:	4 Homicide determined	building, etc.	(Specify)	oon radiory, ornor		City or Town, S	State)	That at House Number,
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of iner: On the basis of e and manner state	xamination and/or in	h occurred at the time vestigation, in my op	e, date and place, an inion, death occurred	id due to the caus d at the time, date	se(s) and manner and place, and o	as stated. due to the cause(s)
	To t Com	Σ	29b. Signature and title of certifier	15 /	_	29c. License		29d.	Date signed (Mo	onth, Day, Year)
				onodi, N			01078		0 23 7	2004
	\		30. Name and address of person who de 22 South Green	ompleted cause of dea	th (Item 23a) (Type,	Print) Ador	a Woned Himore,	MD	DIDA	1
	Stat		31. Date filed (Month, Day, Year)	32. Hegistrar	s Signature	veo, ra	minure,	IVI D	LILU	
	Registra	ar .	NOV 03 2	UO4 Sen	wa &	for .				

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/	Box 68760,
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			Pleas	e Type or Prin									
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P	Physici	an	1. Decedent's Name (First, Middle,		C			-		2. Date of D	eath Da	av Year	3. Time of Death
	/Medi	cal	Clarence E. 4a. Facility Name (If not institution,		Sr.		4h City Tow	m, or Location	of Dogsth	Octobe	2 2	6 2004	4:50 AM
1	Examir	ięr	Sinai Hospita	l of Balti	more	t hirthday)		imore		y		N/A	
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	the Marylar 28a-f ahow nulfited at	Director	Maryland N/	A 	Balti	more							1 X Yes 2 □ No
			3461 Chestnut A	venue			10f. Zip Cod	1211			10g. Ci	itizen of What Cour USA	ntry?
920	or Ita	by Funeral	11. Marital Status 1 Never Married 2 X Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? d 1 7 Yes 2 1 If Yes, Give Year or Dates:	10		Vas Decedent Yes, specify (of Hispanic Or Cuban, Mexica No <i>Specify</i>		ecify Yes or N Rican, etc.)	0-	14. Race - Americ Black, White, Specify: Whi	etc.
2-0		eted	15. Decedent's (Specify only highest	Education grade completed)	1	6a. Deced	ent's Usual Ockind of work do	ccupation one during mos tired)	st of worki	ing	16b. K	(ind of Business/Ind	dustry
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ylaı	ould by Mentity arkect	은	Franklin Patte						Mary	Gray			
	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menlal Hygiene Important: if itam 27 is marked othar than "natuu any injury or other traumatic avent, If a Madical ODGS.		19a. Informant's Name/Relationshi Clarence Patters		n	3815	Address (Str Hickor	y Avent				or Town, State, Zip MD 21211	
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Balti	permit. Departn Imports any inju		21. Sign to Funeral Service Vi	Can bear to	_	Bu	Name and Ad	Idress of Facili	ity eitz	Funeral	l Hoi	me, Inc.	21211
			23a Part1. Enter the disease, or c shock, or heart failure. List or	omplications that caused	the death. D	Do not ente	r the mode of	LS Koad dying, such as	cardiac o	Itimore or respiratory a	⊇, Ma arrest,	aryland	Approximate Interval Between
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E	/Medical Examiner		resulting in death)	Due to (or as		ce of):							
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	Se us	by Pt	Part II. Other significant condition	s contributing to death bu	it not resulting	g in the und	derlying cause	given in Part I.		23e. Did t	obacco u	use contribute to the	e cause of death?
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of	Phyair this cral dir	2	1 Yes 2 No 27. Manner of Death		nt 2 ☐ ER/0	Outpatient	3□ DOA	Other: 4 Nu		ne 5 Resi		6 ☐ Other (Specify)	
ion	ttanding death. stor: Afler	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injur (Month, Day	Year)	Injury		njury at Vork? ☐ Yes 2 ☐ I		.ad. Describe	now injur	y occurred	
Division	or Atta after des Diractor	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ry - At home, (Specify)	farm, stree	et, factory, office	Ce Ce	2	8f. Location (. City or To	Street an wn, State	d Number or Rural)	Route Number,
	Hospita t hours unaral	edical C	29a. Certifier 112 Certifying (Check only one) 2 Medical Ex	Physician: To the best o aminer: On the basis of and manner stat	examination	ige, death o and/or inve	occurred at the estigation, in m	time, date and y opinion, deat	d place, a th occurre	nd due to the	cause(s) date and	and manner as sta place, and due to	ted. the cause(s)
	To tha h within 2 To tha s complete	Me	29b. Signature and title of certifier		The Control of the Co			ense number				e signed (Month, D	
	1			man, M				5-00	00		Och	ober 26	, 2004
	り			o completed cause of de	SINA	a) (Type, P	rint) DSPITA	LOF	BA	LTIMO	RE		
	Sta Registr		31. Date filed (Month, Day, Year) NOV 0 3	2004 32. Registra	r's Signature	6	Spa	K					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month BER 31, 200 **Physician** Poremski Mary L. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore

| Hous | Min. | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar 29 | Mar @ Mercy Stella Maris 7. Age (In yrs. last birthday) 92 Yrs. Social Security Number **Funeral** 217-34-3149 1□M 3€□F Director Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Evaluation retitled at Director Md. Baltimore 10f. Zip Code 10e. Street and Number 21224 400 Gusryan Street MARY 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No þ 3 Midowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be in Department of Health and Mental Important: If Item 27 Is marked o Simon Lustica Cwizk 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Poremski 400 Gusryan Street Baltimore, Md. 21224 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Nov3,04 Baltimore, Md. Holy Rosary Cem 22. Name and Address of Facili Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 1201 Dundalk Avenue Baltimore, Md21222 23a. Part1. Enter the diseas , or complications that can't h shock, or heart failure. List only one cause on each line. the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) rrhosis Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): physician a s the burial-1

Division of Vital Records, P.O. Box 68760, attending ph

Physician/Medical þ Completed 2 Certification:

Medical

After Hospital or Attending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

IF FEMALE: 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No
9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death

4□Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 2 1No 3 Probably 4 Unknown

24a. Was an autopsy performed?	24b. \
1 Yes 2 No	1

28d. Describe how injury occurred

Were autopsy findings available prior to completion of cause of death? Yes 2 🗆 No

34688

3. Time of Death

9. Birthplace (State or Foreign Mary Tand

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 Yes 2 No

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

White

IISA

Specify:

16b. Kind of Business/Industry

Own Home

20c. Location - City or Town, State

25.	Was case examiner? 1 \(\text{Yes} \)		medical
27.	Manner of	5 [Pending

2 🗀 Accident 3 Suicide

4 Homicide

(Check only one)

29a. Certifier

investigation 6 Could not be

Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

9b.	Signature	and title of certifier	
		141	^ -

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
NOV 0 3 2004

301 32. Registrar's Signature

10

State Registrar

State of Maryland / Department of Health and Mental Hygiene 34689 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Year 27, 11:48 A^M October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3219 Montebello Terrace Baltimore
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year 9/22/1913 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M 2 □ F 91 Yrs 215-18-0639 **Director** Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Hehow item 27 is marked other than "natural", or items 23c or 28a-f ebov other traumatic event, the Medical Exacting fring the profiled at MD N/A 1X Yes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3219 Montebello Terrace 21214 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Ellis Louise Cech 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Schuhart/Daughter 3219 Montebello Terrace Baltimore, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or Holy Redeemer 10/30/04 * 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signature of Funera Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. once any 6415 Belair Road Baltimore, Maryland 21206 or complications that care ist only one cause on each line 23a. Part1. Enter the disease od the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failers
Immediate Cause (Final
disease or condition
resulting in death) Onset and Death HSpiratin **Physician** week /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the attending physician and the for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 TYes 2 No investigation completely filled in by the 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier when 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Falls 3730 Kal lt) mare 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 0 3 2004 Registrar

			1 - For State Ragistrar	State of M	aryland / Dep <i>Ce</i>	artment of H <i>rtificate of L</i>	ealth and N Death		giene 0 (04 34690
	Physic /Medi		1. Decedent's Name (First, Middle Marshall L	eigh Rennels	S			2. Date of De Month OCT. 3	ath 0, 2004	Year 3. Time of Death 6:05a M
	Exami		4a. Facility Name (If not institution Joseph Richey	Hospice		4b. City, Town, or Baltimo	re		4c. County of	
	Funeral Director		5. Social Security Number 485-48-3194 Usual Residence of Decedent	6. Sex 7. Ag 1X M 2 ☐ F	e (In yrs. last birthday, 65 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da SEP 2,	th y, Year) 1939	9. Birthplace (State or Foreign Country) Missouri
	e Maryland Be-f show	ctor	10a. State 10b. County Maryland Howa:	rd	10c. City, Town or L	cridge				10d. Inside City Limits 1 □ Yes 2 MNo
	ath with the 23a or 2 ust by n.	rai Dire	10e. Street and Number 5434 Landing	Road		10f. Zip Code 21.07	5		10g. Citizen of WI	nat Country?
960	s 1 and 2 should be filed within 72 hours after death with the Maryland If Health and Mental Hygiene, tiem 27 is markad other than "neturel", or Itams 23a or 28e-f show other traumatic event, the Medical Executer traumatic event, the Medical Executer traust be multified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Amed Forces? ed 1 Tyes 2X	No	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify:	- American Indian, , White, etc. White
Maryland 21215-0036	l within 72 hc iene. r than "netui ir e Madical	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education t grade completed) College (1-4or 5	(Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)	tion uring most of worki	ing	16b. Kind of Bus Universi	ity of Maryland
yland 2	2 should be filed and Mental Hygid is markad other aumatic event, III	To Be C	17. Father's Name (First, Middle, L Ivory Renne)	.ast)	LL		18. Mother's Name	eda Schu	Maiden Surname	of <u>Medicine</u>
	is 1 and 2 shi of Health and item 27 is m other traum		19a. Informant's Name/Relationsh Margaret Baker 20a. Method of Disposition		e 5434	ng Address (Street at Landing Rousition (Name of	ad Elkr		10 21075	itate, Zip Code)
Baltimore,	nit. Page entment o ortant: M injury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service C	ecify)	Metro Cr	ematory or other place	nc. 11/1	./04	Baltimo	ore, MD
ä	perm Dep Impo		Dawn F. 1 23a. Part1. Enter the disease, or o shock, or heart failure. List of	CDonald complications that caused		. Name and Address Cremation 299 Frede er the mode of dying.	erick Roa	d Ralt	imore M	ID 21228 Approximate
P	Physician /Medical Examiner	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a b. Due to (or as a c.	a consequence of):	olon car				Interval Between Onset and Death 3 Yrs
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P.O. Box	that the death cert ed by the attending detached for use a	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 time of death 5	Ectopic pregnancy Other (specify)			23d. Date of Month	
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o	aling Phys I. After this funeral di	To B	examiner? 1 Yes 2 No 27 Manner of Death 1 Natural 5 Pending investiga			28c. Injury a Work?	4 Nursing Horr	ne 5 ☐ Reside		
Divis	itel or Atteners after death	Certification:	3 Suicide 6 Could no 4 Homicide determin	building, etc				City or Town	n, State)	or Rural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	one)	Physician: To the best o xaminer: On the basis of and manner stat	examination and/or inv	estigation, in my opir	nion, death occurre	nd due to the ca d at the time, da	ause(s) and manne ate and place, and	er as stated. idue to the cause(s)
	() E = E = E		29b. Signature and title of certifier 2 (Sa M)	D		D24	17 <i>0</i>	29	od. Date signed (A	Month, Day, Year) (30, 200 4
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.2 F	Sta Registr		31. Date filed (Month, Day, Year)	3 2004 32. Registra	r's Signature	Sport	4			

Marshall Rennels

RPD

Please Type or Print in Black Indelible Ink Freure All Conice Are Legible

70	20		1_ For Amend Item 4c Per		artment of Health and		•	34691
			Registrar 1. Decedent's Name (First, Middle, Last)	Cel	Tillicate of Death	2. Date of Death		3. Time of Death
	Physici	an	Harry William Rock, Jr			October	Day Year	0850 PM
	/Medi Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of De		Baltimor	
1	Examin	iei	I 695 @ Hollins Ferry F		Halethorpe		Anne Art	e Indel
	Funeral Director		5. Social Security Number 6. Sex 10xm 2 F	7. Age (In yrs. last birthday) 51 Yrs.	If Under 1 Year If Under 24 H Months Days Hours Mi			thplace (State or Foreign puntry) ryland
	D >		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	position			10d. Inside City Limits
	aryla shov	5		Baltimore	Addion			1 √ Yes 2 □ No
	the N	ect	MD 10e. Street and Number		10f. Zip Code	10	g. Citizen of What Co	ountry?
	with a sec	0	2803 Georgetown Rd.		21230		U.S.A.	•
	death me 2:	era	11. Marital Status 12. Was D	ecedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur	(Specify Yes or No-	14. Race - Ame	
980	be filed within 72 hours after death with the Maryland that Hyglene. Id other then "natural", or iteme 23e or 28e-f show event, if a Medical Ever it at most be routified at	by Funeral Director	1 Never Married 2 Married 1 Yes.	s 2 XNo	r Yes, specify Cuban, Mexican, Put	erto Hican, etc.)	Black, Whit	
Maryland 21215-0036	thin 72 ho e. en "natur Medical	Completed	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College	d) 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of w DO NOT use retired)	vorking 1	6b. Kind of Business/	Industry
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pu	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Last)			ame (First, Middle, M	laiden Sumame)	
yla		2	Harry W. Rock, Sr.			• Brown		
Jar	12 sho		19a. Informant's Name/Relationship (Type, Print) Elaine Ostovitz/ Siste:		ng Address (Street and Number or Pepperbox Lane		•	Zip Code)
	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		20a. Method of Disposition	20b. Place of Dispo			Oc. Location - City or	Town State
Jor	if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro	m State cemetery, crer	matory or other place)	4		
Baltimore,	permit. Pages 1 a Department of Hea Important: if Item any injury or othe 20028.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Bayview (2. Name and Address of Facility	-03-2004 B	altimore,	Maryland
Ba	Departiment of the particular		The barrens and the same of th	Ar	mbrose Funeral H 719 Hammonds Fer	ome of Lan	sdowne	01007
	Physician /Medical Examiner	Examiner	Sequentially list conditions b.		uries			Onset and Death
Box 68760,	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the buriat-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	to (or as a consequence of): outcome of pregnancy e birth 2 □ Fetal death 3 □	□Ectopic pregnancy		23d. Date of deli	,
P.O. B	that the deal led by the att	hysicia		gnant at time of death 5	Other (specify)		Month	Day Year
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Vital Records,		Completed					ed? prior to death? No 1 XYes	topsy findings available completion of cause of 2 No
V.		Be	25. Was case referred to medical examiner? Wayes 2 No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatien	Othor	eath (Check only one Home 5 Residen		At Comp
of	ing After fune	tion; To	27. Manner of Death 28a. Da	te of Injury onth, Day Year) 28b. Time of Injury Injury	IL 3 DOA 4 Nursing	28d. Describe how		eily) At Scene eratur of Collision
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification;	3 Suicide 6 Could not be 28e. Pla	ice of Injury - At home, farm, str ilding, etc. (Specify)	reet, factory, office	28f. Location (Street, City or Town,	eet and Number of Ru State) I-645 8 No (Dr. M.)	und Davida Alumbad
	hour uner uner		29a. Certifier 1 Certifying Physician: To (Check only 2 Whedical Examiner: On the	the best of my knowledge, death	h occurred at the time, date and pla vestigation, in my opinion, death oc	ce, and due to the cat	use(s) and manner as	stated.
	the H in 24 the F	fedical	one) 22 and m	anner stated.				
ı	To T To T	Σ	29b. Signature and title of certifier	11 112	29c. License number		d. Date signed (Monti	
ŧ			Yamble / Original	(L.MI)	O.C.M.E.	Oc	ctober 31,	2004
_	10		To the total Carry	ause of death (Item 23a) (Type,	Print) 111 Penn Street	, Baltimor	e, Marylar	nd 21201
	Sta Regist		31. Date filed (Month, Day, Year) 32	. Registrar's Signature	Sparket			

			1 - For State of Maryland / De Registrar	partment of Health and Mertificate of Death		ene2 () () (4	34692
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
>	/Medic	al	Vernon Herbert Risseler 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	30, 2004 4c. County of Death	9:00am M
	Examin	er	6200 Old Washington Road	Sykesvill		Carro	11
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y April 15		ace (State or Foreign ry)
٦	g ,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location			d. Inside City Limits
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2	within 72 hours after death with the Maryland ene. Than "natural", or tlems 23a or 28a-f ahow he Madical Examinar must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Amed Forces? 1 Yes 2 No Yes Give Year or Dates:	 Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☑ No Specify: 	o Rican, etc.)	14. Race - America Black, White, e Specify: Whi	tc.
5	72 hou	eted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G	cedent's Usual Occupation	king 16	Bb. Kind of Business/Ind	ustry
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<u>y a</u>	should be nd Mental i markad o imatic eva	To B	Andrew Frederick Risseler		Anna Siltı		
_	S S S S			ailing Address <i>(Street a</i> nd <i>Number or Ru</i> O Old Washington Ro			
ע	es 1 and 3 of Health f itam 27 r othar tr		20a. Method of Disposition 20b. Place of Di	sposition (Name of crematory or other place)	Date 20	c. Location - City or Tov	m, State
	nit. Pages vartment of l cortant: If it injury or o			wn Mem. Gardens 11,		arriottsvil	
מפ	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Licensee Duan, S. Haigh	THATCHT FUNEFALLY HON Sykesville, MD 217	ME & CHAPI 784 (410)-	EL, PA (Box -795-1400	195)
			23a. Part1. Enter the disease, or complications that eaused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Kespi let	ory to	4. 11.04	10 fears
	Examiner		Someofielle list over this or	x Artely d	Deate	state	10 year
۱	ed nsit	nlner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Lunga Punc	0 0	10/1001	0
5	execut an and rial-trar	Examiner	that initiated events c. Due to (or as a consequence of):	myoderalas	uga	1 acon	
0/0	cate be physicie the bu	edical	d				
200	ith certifications in use as			3 □Ectopic pregnancy		23d. Date of deliver	y Day Year
5	the dea by the at ached fo	by Physician/M	1 □ Yes 2 □ No 9 □ Unknown	5 Other (specify)		WOILLI L	Jay 16al
r, L	uires that signed b		Part II. Other significant conditions contributing to death but not resulting in the	10.1 1.0.1.	23e. Did toba	cco use contribute to the	cause of death?
	s been s shoul	plete	Mollitus		24a. Was an	24b. Were autop	sy findings available pletion of cause of
ב	The la	Completed			autopsy performe 1 ☐ Yes 2 ☐	d? death? 1 ☐ Yes 2	
Z	aician: certific rector,	Be	25. Was case referred to medical examiner? Hospital:	Other	th (Check only one)		
5	g Phya er this eral di	n: To	1	e of 28c. Injury at	28d. Describe how	ce 6 □Other (Specify) injury occurred	
VISIO	andin eath. or: Aft the fur	catlo	2 Accident investigation	M 1 Yes 2 No			
	al or Att	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	To the Hospital or Attanding Phyaician: The law requires that the death certificate be executed within 24 hours after death. To tha Funaral Diractor: Attent this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical (29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, digital examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place, r investigation, in my opinion, death occur	and due to the causered at the time, date	se(s) and manner as sta a and place, and due to t	ted. he cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month, D	ay, Year)
$\overline{}$	5		20 None and address of access who are shalled according to the control of	U38413		11/2/0	7
4	11		30. Name and address of person who completed cause of death (Item 23a) (Ty	195 Ston	JER	Aue mey	tunes for
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	I South		2115	7

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 34693 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Dev **Physician** 6:28 am ANTHONY ROLKA 2,2004 NOV. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street and number) Examiner MANORCARE ROSSVILLE BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthptace (State or Foreign Country) 6. Sex **Funeral** Days **X**M 2□ F Months 217-07-9051 95 JUNE 6,1909 MARYLAND Director Usual Residence of Decedent 10c. City. Town or Location 10d. inside City Limits 10a. State 10b. County 1 Yes 2 No Completed by Funeral Directo MD. BALTIMORE DUNDALK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 103 CENTER PLACE U.S.A.

14. Race - American Indian,
Black, White, etc. 21222 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 11. Marital Status 1 Never Married 2 Married Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates: 1943 WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 WELDER WESTERN ELECTRIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN ROLKA VALERIA KOPCZYINSKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2.
Department of Health an Important: If Item 27 is n CAROLYN McFAUL/COUSIN 12901 DULANEY VALLEY RD., GLEN ARM, MD. 21057 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) SACRED HEART OF JESUS 11/5/04 BALTIMORE MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical immediate Cause (Finat disease or condition resulting in death) 3 days Examiner Due to (or as e consequence of) Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Resistant Staphykous bacterenia ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? heart failure 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2☐ No Medical Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fo 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Phyalcian: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as steted.
2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Yeer) 29b. Signature and title of Ce 11/02/04 110055992 completed cause of death (Item 23a) (Type, Print) Are Baltimore MD 21222 Jeboran L. GALLO Holabra 6730 100 NOV 0 3 2004 32. Registrar's Signature State Registrar

MARDICULA ROSSVILL 217-07

			1 - For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H tificate of L			giene 00L	34694
ı	Physic	an	Decedent's Name (First, Middle, Las	,				2. Date of De. Month	_	3. Time of Death
	/Medi Examir	cal	Baby Boy Ren 4a. Eacility Name (If not institution, give			4h City Town or	Location of Death	octoben	18 Dec	12:48 b W
	Cxamir	ier	The Johns Hope	GINS HOS	nital	Beltin	any p	Zu	4c. County of I	Jeath
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8 Date of Birt	h 9.	Birthplace (State or Foreign Country)
	Director		none Usual Residence of Decedent	AM ZUF	Yrs.		Hours Min. 27	Oct 18	2004 1	Maryland
	yland now		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	e Mar 3e-f sl	ctor	MD		Balti	nore				1 ☐ Yes 2¶ No
	with th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	t Country?
	death ns 23s	erai	46860 Hilton Dri	VE 12. Was Decedent E	verintIS 13 V	Vas Decedent of His	20653	acifu Vac or No	USA	American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23a or 28e-f show any rigiuty or other treumatic event, if a Madical Exercifier must be nuitibled at ODGE.	b	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	o If	Vas Decedent of Hi. Yes, specify Cubar ☐ Yes 2X No	Specify:	Rican, etc.)	Black, V	White, etc. White
20	72 ho	eted	15. Decedent's Ed (Specify only highest grad	ucation		ent's Usual Occupa			16b. Kind of Busine	ess/industry
21215-0036	within ane. then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+) life. D	O NOT use retired)) most of work	ing		
	filed v Hygie other t		none I 17. Father's Name (First, Middle, Last)	none	none	unk	18 Mother's Name	a (First Middle	none Maiden Sumame)	
Maryland	Mental Mental arked catic eve	To Be				GIIK		Joy Remu		
ary	2 should and Men Is marke eumatic		19a. Informant's Name/Relationship (T		19b. Mailing	g Address (Street a.			r, City or Town, Stat	'e, Zip Code)
	1 and Health em 27 other tr		Johns Hopkins Hos	pital		N. Wolfe			oe, MD 02	
altimore,	t. Pages I riment of h rient: If ite		20a. Method of Disposition 1 Burial 2 Cremation 3 1 1 Donation 5 Hother (Specify,	in state	7	sition (Name of latory or other place	9)	Date	20c. Location - City	or Town, State
Ba	permit. Departn Importe any inji		21. Sign: w Funeral Sen, ce Licens	11/100	Ba	ltimore,	MD 2120	1	Baltimor	e Street
П			23a. Part 1 Enter the disease, or como shock, or heart failure. List only of	lications that caused in ne cause on each line	the death. Do not ente	r the mode of dying	, such as cardiac o	or respiratory arr	rest,	Approximate Interval Between
	Physician / /Medical	i	Immediate Cause (Final disease or condition resulting in death)	a. Extrem	1011-0-1016	matur	rity			Onset and Death UNIKNOWM
	Examiner			to or as a	consequence of):	011.	1			11. 22
	σ .≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. July to (or as a	consequence of).	, 0		0.	Mery	- INR 2 / MINES
	ificate be executed g physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· PROLONO	consequence of):	erm Kr	ematur	e Kufti	une of prono	the 27 mins es 48 hrs.
68760,	be ex			. Due to (or ascar	consequence or);					
68/	tificate ng phys as the	edicai		d						
O. Box	The law requires that the death cert te has been signed by the attending age 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome o 1□Live birth 2 4□Pregnant at ti 9□Unknown	☐ Fetal death 3 ☐ E	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
_	res that the igned by be detac	/ Ph)	Part II. Other significant conditions col	ntributing to death but	not resulting in the unc	derlying cause giver	n in Part I	23e Did to	acco use contributo	to the cause of death?
Records ,	w requires been sign should be	eted by								Probably 4 Unknown
	(0	Completed						24a. Was ar autops perform 1 X Yes 2	y prior t ned? death	
VItal	Physicien: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	fospital:		O+	26. Place of Death			
	g Physer this eral di	-	27. Manner of Death	1 Inpatient 28a. Date of Injury (Month, Day		3 DOM	4 Nursing Hor		nce 6 □Other (Sp w injury occurred	Decify)
0	Attending I or death. ector: After by the funer	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	28c. Injury a Work? M 1 TY	es 2 🗆 No		,,	
JIVISION	or Attenater deat	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur- building, etc.	y - At home, farm, stree (Specify)	et, factory, office	2	28f. Location (Str City or Town	reet and Number or . . State)	Rural Route Number,
_	pitel o		20a Cartifiar 10 Cartifuing Phys	rigions To the best of					ŕ	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edicai	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medicel Examination Medicel Examination (Check only one)	ner: On the basis of e and manner state	my knowledge, death oxamination and/or inve ed.	occurred at the time estigation, in my opir	, date and place, a nion, death occurre	and due to the ca ad at the time, da	use(s) and manner ate and place, and di	as stated. ue to the cause(s)
	To the To the comp	Me	29b. Signature and title of certifier			29c. License r	number	29	d. Date signed (Mo	nth, Day, Year)
•			· Ubulole (Saw)		56943		10/21/04	/
			30. Name and address of person who co		. 1 16	rint) C+ C-	1	1117 71	nen	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar	N. WOLK s Signature	si pa	ltmore	1840 21	18.1	
	Registra		NOV 0 3 200		was for	Someth				

State of Maniford / Demantment of Health	· · · · · · · · · · · · · · · ·	ł
State of Maryland / Department of Health a	and Mental Hyglen UU [4

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Regis Carmen Raab October 23, 2004 9:04 AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 410 Bar Kess Court Aberdeen Harford 5. Social Security Number if Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Nov 3, 191 **Funeral** Birthplace (State or Foreign Country) 1⊠M 2□F Days Hours Min 208-16-1727 90 Director 1913 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: if Item 27 is marked other than "natural", or Items 23s or 28s-f ahow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f abov other traumatic event, it a Medical Examinar must be notified at MD Harford Be Completed by Funeral Director Aberdeen 1 ☐ Yes 2√ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 Bar Kess Court 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 4 chemist engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Henry Raab Eva Gertrude McCaffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: if Item 27 Is: any injury or other trausonce. Joyce A. Garner/niece 3909 Longley Road Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Sign ture of Foneral Service Licensee Ronal V. S. Wade, State Anatomy Board 655 W. Baltimore Street wan Baltimore, MD 21201 23a. Part1. Enter the disease, of complications triat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cerebral Stroke Acute disease or condition resulting in death) en runutes /Medical Due to (or as a consequence of) to hours Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit attending physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Hypertensia Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dolyon thois 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To 3 DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. within 24 hours after death To the Funerel Director: / completely filled in by the f 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause s) and manner as stated 2 in Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43115 10-26-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615. South Union Ave, Harrede Grace, MD, 21078 MUSS A - 132 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 3 2004

Amend item#5, per Frint in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Continues of Death 1 - For State Registrar 34696 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year MPS 8:25 AM /Medical 27 2004 4a. Facility Name (If not institution, give street and number 4b. City, Town, of Location of Death **Examiner** 4c. County of Death pital enter Mole
If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Sex 1M M 2□ F 8. Date of Birth (Month, Day, Year) 9. Birthptace (State or Foreign Country) Months Days Hours Min. Yrs. Director 1, 1949 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "neturel", or items 23a or 28a-f show the Medical Evanings must be notified at 10d. Inside City Limits Directo 1 Yes XXNo Maryland| Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8229 Reece Heights Drive 21144 United States Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nnt: If item 27 is marked other than "neturel", or items 23. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
11 Yes 2 □ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 If Yes, Give Year or Dates:Vietnam 3 Widowed 4 Divorced Specify White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 years n/a Bartender Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James S. Raidy, Sr. ဂ Amanda Warfield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Brothers (sister) 8229 Reece Heights Drive Severn, Maryland 21144 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 5 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) MD Veterans Cemetery 11-03-2004 Crownsville, Maryland 21. Signature of Rinaral Service Licensee McCully-Polyniak Funeral Home, P.A. m000122 130 E. Fort Ave. Baltimore, MD 23a. Part1. Fater the disease, shook, or heart failure. L or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Intervat Between Onset and Leath ist only one cause on each line ue (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner rounnia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last death certificate be exe Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ moenic Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? Demio 24a. Was an this certificate has Fact Intection 2 No Uringry 2 No 1 Yes 1 Yes 25. Was case referre to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No funeral dir 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 2 Accident 5 Pending within 24 hours after death. To the Funerel Director: A investigation 1 Yes 2 🗌 No Could not be determined 3 🗀 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name a address of p cause of death (Item 23a) (Type, Print) Tohan カフハハ

Registrar

31. Date filed (Month, Day,

Year)

NOV 03

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item: 10e Net ath 11-3-04 eVtor Health and Mental Hydiona

			For State Registrar	d itemate	FMa	irylahd /			it of H te of l			lental Hy	gien Reg. N	200	4	34697
			1. Decedent's Name (First, Middle	e, Last)								2. Date of De			ear	3. Time of Death
Н	Physicia /Medic		Edward J S	Sparwasse	r							Octobe	er 3	30 200	+	4:40PM м
2	Examin	- 11	4a. Facility Name (If not institution	n, give street and n	umber)			4b. City	, Town, or	Location	of Death			c. County of		
			St Joseph Medical			4		Tows	on er 1 Year	If I Indo	r 24 Hrs.			Baltimor		
	Funeral Director		5. Social Security Number 212 22 4239	6. Sex 1 M 2 □ F	80	(In yrs. last	Yrs.	Months		Hours	Min.	8. Date of Bi (Month, Di December	tn 19, Yea 17	"1923 E	Coun	ace (State or Foreign try) Tore, Maryland
			Usual Residence of Decedent	Х	00							Decanica	. т/	1721 1	жили	ibre, raryrain
	yland		10a. State 10b. County			10c. City, T	own or Lo	cation							10	Od. Inside City Limits
	a-fel	ctor	Maryland Baltimo	re		Baltir	more C	ounty	•							1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number Riverthorn 108 Riverthone Ro					10f. Z	ip Code				10g. C	Citizen of Wh	at Coun	iry?
	ath w	rai							220					USA		
	itame	Funeral	11. Marital Status	12. Was De	orces?		13. \	Was Deci f Yes, sp	edent of Hi ecify Cuba	ispanic O in, Mexica	rigin? (Spe an, Puerto	ecify Yes or No Rican, etc.))-	14. Race - Black,	White,	
36	i', or	by F	1 ☐ Never Married 2 ☐ Married 3 € Widowed 4 ☐ Divorced	ried 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ive Dates: r .	J.7 TT		1 ☐ Yes	2[X No	Specify	r:			Specify:	Whi	to
Ö	2 hou atura	ted	15. Deceden	t's Education			6a. Deced	lent's Us	ual Occupa	ation			16b.	Kind of Busi		
212	hin 7.	pie	(Specify only higher Elementary/Secondary (0·12)	st grade completed College		+)	life. L	DO NOT	use retired	1)	st of worki	ing			-	_
2	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itame 23a or 28a-f ehow int, the Modical Extrainer must be notified at	Completed	11	N/A			Ta	vern	Owne					lf-Emp	Toye	ed ,
<u>n</u>	be fill tal H) d oth	Be	17. Father's Name (First, Middle,	,								e (First, Middle		en Sumame)		
<u> </u>	d Men d Men narke	2	Edward Sparwass				101-11-11-		(0)			Petrla				0.11
Maryland 21215-0036	d 2 st th and 7 is n traun		19a. Informant's Name/Relations Jerry Sparwasse					•				a <i>l Route Numb</i> nore, M			ate, Zip	Lode)
	1 and Healt Iam 2		20a. Method of Disposition	1 (3011)		20b. Place	e of Dispo	sition (Na	ame of	1		Date	_	Location - Ci	ty or To	wn, State
on O	ages ant of it: if it y or c		XXXBurial 2 Cremation 4 Donation 5 Other (S		State	Druid	etery, cren Ride	-		′ 1	11-3-	-2004	Ba	ltimor	e. N	/ld -
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23a or 28a-f show appring to other traumatic event, the Machical Examination and be nutified at once.		21. Signature of Funeral Service			DIGIO	100	-		- 1	al Ho		- Du	_ O	, ,	
ä	Depar Impor any ir		Matha Lo	aho Cha	مات			7401	Bela	ir R	d. Ba	altimor	e, N	Md. 21	236	
	100		23a. Part1. Enter the disease, of shock, or heart failure. List	complications that	caused each lin	the death. [Do not ent	er the mo	de of dyin	g, such a	s cardiac o	or respiratory a	rrest,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Al	1-10							10r ,				Onset and Death
	/Medical		resulting in death)	Due to	o (or as a	consequen			4,000-6	,,,,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,	1-16	Cal		
Н	Examiner	_	Sequentially list conditions,													
11	sit ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	d Due to	o (or as a	a consequen	Ce or):									
V:	xector a and	хап	that initiated events resulting in death) Last	c	o (or as a	consequen	ce of):									
8760,	cate be exectred physician and s the burial-transit	dical E														
89	ufficate g phy as the	Ψ.					0-230			= 471						
Вох	death certific attending p	M/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o		of pregnancy 2 Fetal de		Tectonic :	pregnancy					23d. Date		_
	deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at	time of death		Other (s						Month		Day Year
P.O.	at the d by the	by Physician/M	9 🗆 Unknown									00. 511				
	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use a		Part II. Other significant condition	ons contributing to	death bu	it not resultin	ig in the ui	naeriying	cause give	en in Part	1.					e cause of death?
oro	w requir been si should	eted	July 10 Tens	16/6												
Vital Records,	The law ate has t page 2 s	Completed	Mir.al.	1. 6+1/0	vi							24a. Was		pric	re autop r to con th?	ssy findings available aptetion of cause of
a	ician: Th certificate rector, pag		Acnest.	4								1 ☐ Yes	SPIV		Yes	2□ No
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o	y Phy er this eral d	n: To	27. Manner of Death	28a. Date	of Injur	y 28	b. Time of		28c. Injury World			28d. Describe			Specify	,
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Division	Atte ecto by th	ertification;	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac	e of Inju	ıry - At home :. (Specify)	, farm, str	eet, facto	ry, office			28f. Location (City or To			or Rural	Route Number,
Ö	taior rs aft al Dir	Cer				(,				
	a Hospital or Attend 24 hours after death a Funaral Director: etely filled in by the	edical	(Check only 2 Medical	ng Physician: To the Examiner: On the	basis of	examination	dge, death and/or in	occurre vestigation	d at the time	ne, date a pinion, de	nd place, ath occurr	and due to the ed at the time,	cause((s) and mann	er as sta due to	ited. the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director,	Med	29b. Signature and the ocentric	and ma	nner stat	ted.			9c. License					Date signed (
	1 w 6		255. Signature and Mary Continue								C T					
•			30. Name and address of person	who completed as	ISB of do	ath (Itam 03	Ra) (Type	Print)	1100	11				1110	/	
	941		Chrybler	who completed can	.9 UI UE	1/4/7	a, (Type.	1/ 1	4	r 5	lend	18.14	1100	, KA	2	dK
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П	* Registr	ar	TENV A	2 2004	Se	-	A		Lan	40 1						

State of Maryland / Department of Health and Mental Hygien 200 [34698 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 37 2000 2004 Physician 5.30AM Schmid /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 603 Nolberry Drive Glen Burnie, Anne Arundel 8. Date of Birth (Month, Day Year) 1930 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country)
 Md 7 Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 ☐ F 74 578 36 6447 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City. Town or Location 10a, State show the Medical Examiner must be nutilised at 1 Yes 2 No Director Anne Arundel Glen Burnie 28a-1 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code or Items 23a or 21061 603 Nolberry Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygiens Important: If item 27 is marked other than any niury or other traumatic event, that ones. Quality Control Director Westinghouse 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Frank Schmid Dorothy Bollig Davis Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 603 Nolberry Drive Glen Burnie. Md. 21061 Zoe Schmid (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Cremation 11 2 04 Stevenville, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 1 Second Ave Sw Cero Singleton Funeral Home, P.A.Glen Burnie Md.21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-tran the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No should be detached 9☐ Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by /wou are 2 (No 320 1 Tyes 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 : autopsy performed 2 No certificate 1 Yes Physicien: completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Mesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death After Attending 1 Natural Injury 5 Pending 1 TYes 2 ∏No investigation hours after death 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö within 24 hours a To the Funerei L To the Hospitel (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of cert 30. Name and address of person who -y pl ed cause of death (Item 23a) (Type, Print) 000 Cas 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

ORIGINAL

		1- For State of Maryland / Department of Health and Certificate of Death		2004 34699
Physi	cian	1. Decedent's Name (First, Middle, Last) Wapel Adessa Sullivan	2. Date of Death Month	Day Year 3. Time of Death
/Med Exam		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De		4c. County of Death
	P	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H	rs. 8. Date of Birth	ANNE ARUNIDEL
Funera Directo		121-20-0196 1 M 2 F 81 Yrs. Months Days Hours Mi		9. Birthplace (State or Foreign Country) New York
land bw		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
a-feh	ptor	MD Anne Arundel Pasadena		1 ☐ Yes 2 ☐ No
with the	Director	10e. Street and Number 10f. Zip Code 21122	-	. Citizen of What Country?
death ma 23	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?		U.S.A. 14. Race - American Indian,
ite, Mal yial to ZIZIS-0030 s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23s or 28s-1 show other traumatic event, the Medical Estantiant must be multibled at	2	If Yes, Give 1 ☐ Yes 2 🛣 No Specify: Year or Dates:	erto Rican, etc.)	Black, White, etc. Specify: African American
72 ho	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work done during m	vorking 16	b. Kind of Business/Industry
s within liene.	a de	Elementary/Secondary (0-12) College (1-4or 5+) 4 Nurse		Hospital
be filectal Hyg	å	17. Father's Name (<i>First, Middle, Last</i>) 18. Mother's N	lame (First, Middle, Mai	
hould In Men marke	٢	Frank Archibald Tully, Sr. Cec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or a	ilia Codrin	1545
ING 2 salth an 27 is or trau		Mrs. Lorraine Roberts/daughter 7841 Red Lion Way, P		
partitione, management Peges 1 and 2 Department of Health a Important: if Item 27 is any injury or other tra	1	20a. Method of Disposition 1 ■ 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 200	c. Location - City or Town, State
mit. Peges partment of portant: if it y injury or of	۵	`4 □Donation 5 □Other (Specify) Cedar Hill Cemetery 10/		cooklyn, MD
Ped Ded King		21. Signature of Eneral Service according to the Second Avenue S	.W., Glen F	neral Home P.A. Burnie, MD 21061
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.	iac or respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medica	_	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		Oliset and Death
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De tist	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying		
execu-	Exan	resulting in death) Last Due to (or as a consequence of):		
ficate be executed physicien and sthe burial-transit	edicai	d		
ath certific titending p	M/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant		23d. Date of delivery
that the death certined by the attending detached for use a	Physician/M	in the past 12 months: 1		Month Day Year
S that i	by Ph		23e. Did tobac	co use contribute to the cause of death?
iw requires that s been signed t should be dett			1 ☐ Yes	2 No 3 Probably 4 Munknown
M 00 00 CV	Completed		24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 ☐ Yes 2 ☑ No
sician: T scertificat irector, p	o Be	examiner?	eath (Check only one)	0.50
ng Phy ter this	11	The state of the s	Home 5 Residence 28d. Describe how i	
Attending or death.	ertification:	2 Accident investigation 3 Suicide 6 Could not be	004 1	
al or A safter of Direct	ertif	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, S	t and Number or Rural Route Number, tate)
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
To ti Withli To th	M	29b. Signature and file of certifier 29c. License number		Date signed (Month, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) (Type/Ryint)	0	0015EK 24 2004
Î)	30. Name and address of person who completed cause of death (Item 23a) (Typer Rint) 31. Date filed (Month, Day Year) 32. Registrar's Signature	Burrue	MD 21061.
S Regis	tate trar	31. Date into (word), 22. negstrars signature		

ORIGINAL

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiens - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Physician October 24, 2004 John Frank Serio 22:29 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Sinai Hospital Baltimore Baltimore City If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec 20, 19 Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Months 1**X** M 2 ☐ F 77 Yrs. Dec **Director** 217-34-9439 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County , or Itams 23a or 28a-f show aminer must be multipled at MD Carroll Sykesville 1 ☐ Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 639 Green Valley Way 21784 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status other traumatic event, the Madical Examiner of Amed Forces:

1 MYes 2 No
If Yes, Give
Year or Dates: Korea 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛱 No Specify: Specify: White à 31☑ Widowed 4 ☐ Divorced "netural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Produce Store Owner Produce 12 t. Pages 1 and 2 should be filed value to Health and Mental Hygie tent: If itam 27 is marked other t 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Salvatore Serio Antonietta Glorioso 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John Serio (Son) 639 Green Valley Way Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Importent: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 10/29/04 Baltimore, MD 21. Signature of Funeral Service Licensee PATGHT FUNERAL HOME & CHAPEL PA (Box 195) Sykesville, Fib 21784 (410)-795-1400 uan 0 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Deilar disease or condition /Medical resulting in death) Due to (or as a consequence of) untroum Examiner Disso se Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. by Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy ō Day Month Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No detached the 9 Unknown 9 I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Monknown Completed should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 SER/Outpatient ည 1 ☐ Yes 2 🙀 No 3□ DOA this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After t Certification: Natural 5 Pending investigation м 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death a Funeral Diractor: 6 Could not be 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only within 2 one) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie D5075 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a Delegane Die Bollingre 2434 AN. ROLATOR 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

WOV A 3. 2004

Registrar

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Registrar's Signature

		Department of Health and Mental Hy Certificate of Death	•
Physician /Medical	00 111(47V) 07 3m(174	2. Date of De Month Corrector	eath 3. Time of Death
Examiner Funeral Director	5. Social Security Number 214-26-4922 5. Social Security Number 5. Sex 7. Age (In yrs. last in the security Number) 7. Age (In yrs. last in the security Number)	birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7/16/1	4c. County of Death Anne Annadel
death with the Maryland rms 23a or 28e-1 show rmust be notified at		own or Location GLEN BURNIE	10d. Inside City Limits 1 □ Yes XX No
of the Mark the Mark the Mark them 23a or 28e-1 sindiffer must be notified Funeral Director	10e. Street and Number 203 MARLEY NECK ROAD	10f. Zip Code 21060	10g. Citizen of What Country? USA
215-0036 Sin 'naturel', or Items 23a or 28e-1 show Medical Examinar must be notified at poleted by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes ★ No Specify:	14. Race - American Indian, Black, White, etc. Specify: WHITE
121215-00 led within 72 hou yajenen ner then "nature it, the Medical Ent. Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Ga. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Maryland 21215-0036 to 2 should be filed within 72 hours all that Medical Hygiene. 77 is marked other then "naturel", or traumatic event, the Medical Exami	17. Father's Name (First, Middle, Last)	WELDER 18. Mother's Name (First, Middle,	
Maryla ### And Men ### T Is marke traumatic To	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street and Number or Rural Route Number	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depa trainent of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	20a. Method of Disposition XXBurial 2	426 CRAIN HIGHWAY S., GLE	BALTIMORE, MARYLAND ERAL HOME, PA IN BURNIE, MD 21061
Physician /Medical	23a. Pan 1. Enter the disease, or complications that caused the death. Dishock, or heart stillure. List only one cause on each line. Immediate Cause (Final disease or candition resulting in death)	Failure	rrest, Approximate Interval Between Onset and Death
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Left lewer can be consequence).	heart failure 1 lobe preumonia	2 wasks
68760, tificate be ex g physician as the burial		tructive lung disease	years
Vital Records, P.O. Box 68760, sician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit be Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown	tth 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
ords, P equires that een signed b could be deta			obacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown
tal Records, in: The law requires tallificate has been signe or, page 2 should be or	25. Was case referred to medical	24a. Was autop perfo 1 U Yes 26. Place of Death Check onlo	prior to completion of cause of death? 1 Yes 2 No
n of ng Phys ng Phys uter this uneral di on; To	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/C	Dutpatient 3 DOA Other: 4 Nursing Home 5 Residence Residence Nursing Home 5 Residence Resi	dence 6 Other (Specify) now injury occurred Street and Number or Rural Route Number.
Divisio To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		ge, death occurred at the time, date and place, and due to the o and/or investigation, in my opinion, death occurred at the time, of	CAUSE(s) and manner as stated
To the within To the comple	29b. Signature and title of certifier		29d. Date signed (Month, Day, Year) October 26, 2004
Cotty		ptal Dr. Suite 305 Glen !	Burnie, MD 2106
State Registrar	31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature	5 Sparks	

Amend item # 24a, pentil, G637, 11/3/04, 11

		- negistrar	State of Marylan	d / Depa	tificate of L	ealth and Death		Reg. No.	004	
Phys /Me	ician dical	1. Decedent's Name (First, Middle, Last) Geneva Martha	Shiflet				2. Date of Do		2004 ^{ear}	3. Time of Death 5:30 am
Exan		4a. Facility Name (If not institution, give st Southern Maryla		-	4b. City, Town, or Clin		th		ounty of Death nce G	eorges
Funera Directo		5. Social Security Number 6. Sex 5 7 8 - 1 6 - 8 0 7 3	7. Age (In yrs. I	ast birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		rth ² / ₂ 1 9 2 1		place (State or Foreign intry) Tgia
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County Prince G		on H	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the 3a or 28a	I Director	10e. Street and Number 1319 Crisfield	Dr.	-	10f. Zip Code 2 0	745		10g. Citize	on of What Cou	
15-UU36 n 72 hours after death with the Maryland n 72 hours after death with the Maryland natural; or Itams 23e or 28e-f ehow edical Exeminer must be notified at	by Funeral	11. Marital Status 1: 1 Never Married 2 Married **Control Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ∐Yes 2 ∐ANo If Yes, Give Year or Dates:	1	Vas Decedent of Hi Yes, specify Cubar ☐ Yes 2 No	spanic Origin? (S n, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - Amer Black, White pecify: B1	ican Indian, , etc. ack
rithin and and and and and and and and and an	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Deced (Give life. D	ent's Usual Occupa kind of work done of DO NOT use retired, Clerk	ution luring most of wo	rking		of Business/Ir	*
d be ental	To Be Co	17. Father's Name (First, Middle, Last) George Bank	(S			18. Mother's Na Annie	me (First, Middle Hope		umame)	_
		19a. Informant's Name/Relationship (Type Arvis Powell/ D	e, Print) aughter	19b. Mailin 1319	g Address (Street a Crisfie	nd Number or R. 1d Dr.	ural Route Numb • 0xon	Hill	own, State, Zij , MD	20745
Baltimore, bermit. Pages 1 ar Department of Hea Important: If Item any injury or other		20a. Method of Disposition 1 XBurial 2 Cremation 3 Re 4 Donation 5 Other (Specify)	moval from State	emetery, crem	sition (Name of atory or other place tion Ce	m. 11-	Date 5 - 0 4		tion - City or T	
Baltimo permit. Page Department Important: If	<u>000</u> 0	21. Signature of Funeral Service Literises	ilos		Name and Addres					
Physicia /Medica Examine	al er	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, b.	Due to (or as a consequ	Do not ente	r the mode of dying		c or respiratory a			Approximate Interval Between Onset and Death
68 / 60, ificate be executed g physician and as the burial-transit	edical Examiner	if arry, leading to infinediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last d. d.	Due to (or as a consequ					41		
death certi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Do 9 Unknown	c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3 🗌	Ectopic pregnancy Other (specify)			230	d. Date of delive	ery Day Year
rds, F.O. I quires that the de in signed by the a uld be detached f	þ	Part II. Other significant conditions cont	ributing to death but not resu	Ilting in the un	derlying cause give	n in Part I.				he cause of death? pably 4 Denknown
VITAI KECOTAS, P.O. Iclan: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed							an psy prmed? 2 X No	24b. Were auto prior to co death? 1 Yes	opsy findings available impletion of cause of
OT VITAL Phyalclan: The rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 1 Yes 2100	spital: 1 dinatient 2 E	ER/Outpatient	3 DOA Othe	-	ath <i>(Check only c</i> fome 5 \to Residen		Other (Specif	(y)
VISION O		27. Manner Death 1 Platural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? es 2 □ No	28d. Describe	how injury o	ccurred	
DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Diractor: Atter this certific completely filled in by the funeral director,	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, stre)	et, factory, office		28f. Location (City or To		lumber or Rura	al Route Number,
ne Hospl 124 hour 14 Funer Metely fill	edical	29a. Certifier (Check only one) 1 Certifying Physic Physics (Check only one)	cian: To the best of my know er: On the basis of examinati and manner stated.	viedge, death ion and/or inv	occurred at the time estigation, in my op	e, date and place inion, death occu	, and due to the irred at the time,	cause(s) ar date and pl	d manner as s ace, and due to	tated. the cause(s)
To th To th	Me	29b. Signature and title of certifier			29c. License				igned (Month,	
Û.		30. Name and address of person who com		23a) (Type, F		,	mD 20			9,04
	State strar	31. Date Med (Month, Day, Year) 201	32. Registrar's Signat		for "	/	147 56	10	-	

DHMH 17 Rev 1/2001

NOVEMBER

STOVALI

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 34706 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yeer **Physician** Stewart Lillie 28 2004 12:30p October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince Georges Hospital Cheverly Prince Georges Comm. | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | O 5 | O 6 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number Year) 39 **Funeral** 1 ☐ M 2 🔀 F 213-36-6979 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State ir than "natural", or Itama 23a or 28a-f show 1 ☐ Yes 2 No Prince Georges Bowie Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20716 Ct. death v 16311 Epsilon Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ Mo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: by Black 3 Widowed Wivorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) other than College (1-4or 5+) Elementary/Secondary (0-12) Recreation Leader Baltimore City 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If Item 27 is marked oth any injury or other traumatic event gnes. Be Elizabeth Featherstone John Brandon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharon D. Stewart-Daughter 16311 Epsilon Ct. Bowie, Md

Oa. Method of Disposition

Obs. Place of Disposition (Name of cemetery, crematory or other place)

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md

Oct. Bowie, Md 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 11/01/04 Arbutus, Md 21. Signature of Juneral Service Licenses 22. Name and Address of Facility March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Duyth (or as a considuence of) **Examiner** re Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initrated events Oue to for as a consequence of) Examinet The law requires that the death certificate be executed enou use as the burial-tran and resulting in death) Last the attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 Yes 2 No detached P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. λq of Vital Records, þe 2 X io 3 Probably 4 □Unknown 1 Tes Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: Other: 1 Napatient 2 📮 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes this filled in by the funeral ate of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. 27. Manyfer of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident death 24 hours after deat a Funaral Diractor: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 3 2004 Spark Registrar

		•	1 - For State Registrer	of Maryland / D	epartment of l Certificate of	Health and M <i>Death</i>	Reg.		34707
	Physicia		Decedent's Name (First, Middle, Last) M. C. Cl. 11				2. Date of Death Month October 3	Day 2004	3. Time of Death 5:45 PMM
	/Medic	al	Mary C. Shallcross 4a. Facility Name (If not institution, give street and	number)	4b. City, Town,	or Location of Death		4c. County of Death	
	Examin	er	Quail Run Assisted Liv		Parkv			Baltimore	
	Funeral Director		5. Social Security Number 212-07-2624 6. Sex 1 □ M 2 🛣	7. Age (In yrs. last birtl 96	hday) If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye May 5, 19	ar) Cou	place (State or Foreign ntry) yland
	/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	e Man Sa-f sh	ctor	Maryland Baltimore	Parkvi					XXYes 2 □ No
	th with th	al Director	1902 Walther Blvd		10f. Zip Code 2123			Citizen of What Cou USA	A
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, Ir a Madical Evar, in at frout the multiplication and page.	Completed by Funeral	1 Never Married 2 Married 1 Yes.	ecedent Ever in U.S. Forces? es 2/T/No Give r Dates:	13. Was Decedent of If Yes, specify Cult		ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: Wh	
Maryland 21215-0036	in 72 ho	ieted	15. Decedent's Education (Specify only highest grade complete	9d)	Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	during most of work	ing 16b	. Kind of Business/Ir	ndustry
212	d withi	Somp	Elementary/Secondary (0-12) Colleg Unknown	e (1-4or 5+)	Insurance			Insura	nce
nd	be file ital Hy id othi	Be	17. Father's Name (First, Middle, Last) Joseph Shallcross				e (First, Middle, Maid ary A. Nag		
Z	should nd Mer marke matic	은	Joseph Shallcross 19a. Informant's Name/Relationship (Type, Print)	19b.	Mailing Address (Stree	at and Number or Ru	al Route Number, Ci	ity or Town, State, Zi	p Code)
, Ma	and 2 salth ar		Patricia King Nied	e 1	1404 Medfie	1d Avenue	Baltimor	re, Maryla	nd 21211
Baltimore,	Pages 1 and part of He ent: If item		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal fr 4 □ Donaron 5 □ Other (Specify)	om State 20b. Place of cometen	Disposition (Name of y, crematory or other pla athedral Ce	metery 11,	Date 200 /3/04 Ba	Location - City or Taltimore,	
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Licentee	uss	3631 Fa11	s Road, Ba	Funeral H	Maryland	21211
			23a. Part1. Exter the disease, or complications the shock, or heart failure. List only one cause Immediate Cause (Final	at caused the death. Do non each line.	not enter the mode of dy	ring, such as cardiac			Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	to (or as a consequence of	of): C - 0	7 1	ISEAS		
Ī	Examiner		Sequentially list conditions, b.	TRIAL		CLC ATI	10%		
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of	ATION	,			
ó	ate be executed obysician and the burial-transit		resulting in death) Last	to (or as a consequence of	of):				
8760,	icate be physici s the bu	dicai	d. D	EMENT!	<i>11</i>				
.O. Box 6	death certif e attending id for use at	Physician/Med	in the past 12 months?	outcome of pregnancy we birth 2 Fetal death regnant at time of death nknown	3 ☐Ectopic pregnan 5 ☐ Other (specify)	су		23d. Date of delive Month	rery Day Year
О.	uires that I signed by	by	Part II. Other significant conditions contributing	o death but not resulting in	n the underlying cause g	iven in Part I.	23e. Did tobac	co use contribute to	_
Records,	The law requires that the rate has been signed by the page 2 should be detache	ompieted					24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Vital		Be C	25. Was case referred to medical examiner?				th (Check only one)		1355/5+2el
of V	Physic this c	2		☐ Inpatient 2 ☐ ER/Ou ate of Injury 28b. T	TPATIENT 3 DOA		ome 5 Residence		ity) Living
ion	Attanding Physicien: r death. ector: After this certific. by the funeral director,	ation	1 Datural 5 Pending (2 Accident investigation		njury W	ork? □Yes 2□No			
Division	in Die	Certification:	3 Suicide 6 Could not be 28e. P	lace of Injury - At home, fai uilding, etc. (Specify)	rm, street, factory, office	Э	28f. Location (Stree City or Town, S	t and Number or Rui itate)	ral Route Number,
	To the Hospital within 24 hours a To tha Funaral I completely filled	Medical ((Check only 2 Medicel Exeminer: On the	the best of my knowledge ne basis of examination and nanner stated.	e, death occurred at the d/or investigation, in my	time, date and place, opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
)	To the To the Complex of the Complex	Σ	29b. Signaturand title of certifier	Time !	29c. Licer	27/82	? 29d.	Date signed (Month) $O/31/2$	pay, Year)
	13		30. Name and address of person who completed	cause of deam (liem 23a) ((Type, Print)	17/10	o Du	a Dale	40
		ate	31. Date filed (Month, Day, Year)	2. Registrar's Signature	1417		- 41		
DH	Regist		NOV 0 3 2004	Beneva	& Span	B			

ORIGINAL

State of Maryland / Department of Health and Mental Hygiena Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** OCTOSER 20 2004 /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner NORTHWEST RANDALISTOUN SUBACUTE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) April 21 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F 212-18-7704 1918 Pennsylvania 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes XXNo Columbia Maryland Director Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 21045 UNK 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 ö 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) never worked -0never worked permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Barney Fannie Saltzman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Waissman Brother in Law 4730 Atrium Court, Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State MBurial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Heb Hebrew Friendship Cemetery October 22, 2004 Baltimore, MD 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Funeral Service Dicensee alman MOOJJJ 8728 Liberty Rd., Randallstown, MD 21133-4784 7-1 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate causa. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner physician and the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 4 Pregnant at time of death 5 Other (specify) P.O. | 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably as been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 certificate 1 Yes 25. Was case referred o medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 2 No Other: 4 ☐ sing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification; After 1 Whitural Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Diractor: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dira 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 37333 OCTO SER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAVI NHC 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar NOV 0 3 2004

			For State Registrar	State of M	arylan		artmeni rtificate					jiene	004	34709
	Dhusisi		1. Decedent's Name (First, Middle								2. Date of Dear Month	th Day	Yea	3. Time of Death
	Physici: /Medic		Sarah Odell								Octobe	r 28	, 2004	9:00 AM M
	Examin	er	4a. Facility Name (If not institution	-					Location of	of Death			County of De	
			Randolph Hi 5. Social Security Number			ast birthday)	Whea If Under		If Under	24 Hrs.	8 Date of Birth		ntgome	ry inhplace (State or Foreign
	Funeral Director		722-05-0139	1□ M 2∏F	80	Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month Day May 8	192	4 Ge	orgia
			Usual Residence of Decedent		1									Ţ
	anylar show	2	MD 10b. County Montg	omerv	10c. Cit	y, Town or Lo Wheat								10d. Inside City Limits 1 ☐ Yes 2∑ No
	ith the Marylar or 28a-f show	ecto	10e. Street and Number				10f. Zip	Code			1	On Citiz	en of What	
3	with Sa or	Funeral Director	4011 Randolph	Road			101. 210		902		'	US US		Southly ?
	death ms 23	era	11. Marital Status	12. Was Decedent	Ever in U	.S. 13.	Was Deced			gin? (Spe	ecify Yes or No- Rican, etc.)		4. Race - Ar	nerican Indian,
2	or Ite		1 ☐ Never Married 2X Marr	ied Armed Forces 1 ☐ Yes 2 🔀 If Yes, Give			iryes,spec 1 ⊟ Yes 2		n, mexicar Specify:		Hican, etc.)		Black, Wi	
3	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If tien 27 is merked other then "neturel", or items 23a or 28a-f show any injury or other treumatic event, the Medical Exammer Fright be invitibled at once.	d by	3 Widowed 4 Divorced	Year or Dates:				- 20					Specify: W	
	"neti	Completed	15. Deceden (Specify only highes			(Give	dent's Usua kind of wor DO NOT us	k done d	turina mos	t of work	ing	16b. Kin	nd of Busines	s/Industry
4	withii lene. then	dmc	Elementary/Secondary (0-12)	College (1-4or	5+)		usewi		,				own ho	
2	filed Hygi other	a)	17. Father's Name (First, Middle,	Last)		110	ADC WI		18. Mothe	er's Name	First, Middle, I			me
5	should be ind Mental i marked o imatic eve	OB	James Cory	Banks]	Este:	ll Steph	ens		
2	2 sho and h is ma		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	al Route Number	, City or	Town, State	, Zip Code)
	and and ealth m 27		Jean Pierson/d	aughter	Tool 5	304	Buttr	y Ro	ad Ga		rsburg,			
5	Pages 1 and nent of Health nt: If item 27 iry or other to		20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 □Removal from State		Place of Dispo cemetery, crea	matory or o	ne or ther plac	θ)		Date	20c. Loc	ation - City o	or Town, State
	it. Pa ntmen rtent: njury		 4 ☑ Donation 5 ☐ Other (S 21. Signature of Funeral Service 		71_	200	2. Name an	d Addres	o of Equilit					
ם ס	permit. Departr Importe any inju		Ronald	S Wade, Diy	ector						₁ 655 W.	Bal:	timore	Street
	-		23a. Part1. Enter the disease, or	omplications that cause	d the deat									Approximate
	Physician		shock, ir heart failure. List Immediate Cause (Final				NOOTO							Interval Between Onset and Death 25 years
	/Medical		disease or condition resulting in death)	a Due to (or as		SCLFI uence of):	(0212							2) years
	Examiner		Sequentially list conditions.	b										
	sit 9d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseq	uence of):								
	be executed ician and burial-transit	хаш	that initiated events resulting in death) Last	c Due to (or as	s a conseq	uence of);								
5	cate be executed physician and the burial-transit	dical E			·	ŕ								
	ificate g physi		_	0.										
5	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as	hysician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-			Ectopic pr	2002001				2:	3d. Date of d	elivery
	deatl	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a			Other (sp						Month	Day Year
	uires that the de signed by the a Id be detached f	Phy	9 Unknown			Marchards a			1. B I		One District			to the cause of death?
ń	ires the signer	by	Part II. Other significant condition	ons contributing to death	but not res	uiting in the a	nderlying ci	inze dive	en in Part i		230. Did tot			Probably 4 Unknown
5	w requir been si should	eted												
ב	has l	ompleted									24a. Was a autops perform	sy	prior to death?	autopsy findings available completion of cause of
		e Co	25. Was case referred to medica						00 01	-4 D4		No No	1 □ Ye	
5	/sicie s cert direct	o B	examiner?	Hospital: 1 ☐ Inpat	ient 2 🗆	ER/Outpatier	nt 3 🗆 DO	A Othe			n <i>(Check only on</i> me 5 ☐ Reside		□Other /Sr	necify)
5	Attending Physicien: The la sr death. sector: After this certificate has by the funeral director, page 2	T:u	27. Manner of Death	28a. Date of Inj	ury	28b. Time o		Bc. Injury Work	at		28d. Describe ho			00.77
2	endin vath. or: Aff	Certification:	Natural 5 Pendir investi	gation		,	М		res 2□	No				
2	I or Attendi after death. Director: A I in by the fu	rtiflo	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 286. Place of Ir	njury - At he	ome, farm, str	eet, factory	, office			28f. Location (St City or Town		Number or I	Rural Route Number,
כ	To the Hospital or Attending Physicien: within 24 hours after deals as a fer deals To the Funerel Director: After this certifica completely filled in by the funeral director,		CON CAMPINA AND CAMPINA	a Chuaisia a Turi					4	1.1				
	To the Hospital within 24 hours To the Funerel completely filled	edical		ng Physician: To the bes Examiner: On the basis and manner s	of examina									
	To the within 2 To the complet	Med	29b. Signature and title of certifie				29c	. License	number		2	9d. Date	signed (Mo	nth, Day, Year)
	->-0		1 Meeter 9	- 8m. e	2			DUS	3944			10)/20/2	004
			30. Name and address of person	who completed ause of	death (Iten	п 23а) (Туре,	Print)	200					,,	
			DR MARTIN C	SHARGEL 3			T AVE	. KE	NSIN	GTON.	MD 2089	5		
	Sta	ite	31. Date filed (Month, Day, Year)	32 Regist	trar's Signa	ature	Ann	1	/,					

State of Maryland / Department of Health and Mental Hygien [] [] 34710 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** October Sparks Robert Shifflett 2004 06:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1₩ 2□F Yrs. Director 230-10-9492 84 June 9, 1920 Virginia Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 28e-f show r then "netural", or Items 23a or 28e-f show the Medical Examinations be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 415 S. Market St. 21078 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☑ Yes 2 ☐ No ff Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed by 3 ☐ Widowed 4 € Divorced WWTT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) milt. Pages 1 and 2 should be fit pertment of Health and Mental Hepotrant: If Item 27 is marked off y injury or other traumatic even Be Herman (nmn) Shifflett Lelia E. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Shifflett - Son 5 Highview Rd., Conowingo, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Garrison Forest VA Cem. 11-5-04 Owings Mills, MD 21. Sign has of Funeral Servic Licensee

Mc Comas Funeral Home

1317 Cokesbury Road, Abingdon, Maryland 21000

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death

Company Final

22. Name and Address of Funeral Home

1317 Cokesbury Road, Abingdon, Maryland 21000

Approximate interval Between Onset and Death

Company Final permit. F Departmo Importar any injur Physician /Medical **Examiner** ZWKE necemons-9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? res 2.0 No certificate 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Certification; To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 6 Could not be determined 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ö To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wilham MD D32609 30. Name and address of person who completed cause of death (Item 23a) (Type, Print).
Kamneden Milham MD 1106 Revalution St. Howe De Grace MD 21078 31. Date filed 10 10 30 30 2004 32 Registrar's Signature State

Registrar

B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State Registrar			artment of			Reg. No. U	34711
	Physici /Medi		Decedent's Name (First, Middle, Last LORRAI			STEI	N	2. Date of De Month NOV.	1, Day 2004	Year 3. Time of Death 0325 A M
1	Examir		4a. Facility Name (If not institution, give 3828 JANBROOK ROA	street and number)		4b. City, Town	n, or Location of LLSTOWN	Death	4c. County	
	Funeral Director		5. Social Security Number 6. Se 122-32-7491		(In yrs. last birthday) 68 Yrs.	If Under 1 Ye Months Day		Min. 8. Date of Bin (Month, Da MAY 22	th y, Year) 1936	Birthplace (State or Foreign Country) NY
	Maryland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Ma 28a-1 s	Director	MD BA	LTIMORE		10f. Zip Cod		LLSTOWN	10g. Citizen of V	1 Tes 2 No
	death with the rms 23a or 28a r must be noti	al Di	3828 JANBROOK ROA	D		Toi. Zip Cod	21133		TOG. CITIZET OF V	USA
980	72 hours after des natural', or items iteal Examinar m	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 🏋 Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 M N If Yes, Give Year or Dates:	lo	Was Decedent of f Yes, specify C 1 ☐ Yes 2 🌠 N		n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race Blac Specify	e - American Indian, kk, White, etc. :: WHITE
Maryland 21215-0036	- 34	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 12		+)	dent's Usual Oci kind of work do: DO NOT use ret CE MANA	cupation ne during most of tired) GER	of working	16b. Kind of Bu	,
/land	should be filed withir nd Mental Hygiene. marked other than imatic avent, I'le Mi	To Be C	17. Father's Name (First, Middle, Last) SALVATORE	Α.	ESPOSI	T0		s Name <i>(First, Middl</i> e, LINE	Maiden Sumam	TAUBENFELD
	ss 1 and 2 sho of Health and I item 27 Is me r other treums		19a. Informant's Name/Relationship (7)		3828	JANBRO	OK ROAD	or Rural Route Numbe - RANDALLS		
nore	ages 1 ant of H at: If itan y or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		20b. Place of Dispo cemetery, cren			Date 11/2/2004		BALTIMORE, MD
Baltimore,	permit. Page Department of Importent: If any injury or once.		21. Signature of Funeral Service Licens		22	. Name and Add	dress of Facility	SOL LEVINS	SON & BR	
	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition	ne cause on each line	the death. Do not ent e. sclerotic (rest,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
٧.	cur a d nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	เ ฉอกรองุนยกขอ ข้า).					
8760,	cate be executed oblysician and the burial-transit	dical Ex	resulting in death) Last	Due to (or as a	consequence of):					
O. Box 6	The law requires that the death certific tie has been signed by the attending p page 2 should be detached for use as:	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of 1□Live birth 2 4□Pregnant at t 9□Unknown	Petal death 3□	Ectopic pregnal			23d. Date Mon	e of delivery th Day Year
rds, P.	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions con		t not resulting in the ur	nderlying cause	given in Part I.	23e. Did to	N 2	bute to the cause of death?
Il Records,	i ician: The law requ certificate has been rector, page 2 shoule	Completed by						24a. Was a autop. perfor	sy pr med? de	Vere autopsy findings available rior to completion of cause of eath? Yes 2 \sum No
of Vital	Physician: r this certific ral director.	Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No	lospital: 1 ☐ Inpatien	it 2 ☐ ER/Outpatien	30.004	2.1	f Death (Check only or		r (Specify) AT SCENE
ion of	Attending Physr death. cdeath. sctor: After this y the funeral di	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day		28c. In	4 🗆 Nurs	28d. Describe h	ow injury occurre	
Division	tal or Attenors after death birector:	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur building, etc.	ry - At home, farm, stre (Specify)	eet, factory, offic	ce	28f. Location (S City or Tow	treet and Numbe n, State)	r or Rural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To tha Funeral Director: After this certificate h completely filled in by the funeral director, page	edical	one)	sicien: To the best of ner: On the basis of and manner hat	examination and/or inv	estigation, in my	y opinion, death	place, and due to the coccurred at the time, co	late and place, ar	nd due to the cause(s)
	To tha within 2 To tha Comple	M	29b. Signature and title of certifier	t DV	√ ∽,		C.M.E	2		(Month, Day, Year)
	12		30. Name and address of erson co	PISI - D	ath (Item 23a) (Type, I 111 Penr		, Balti	more, Mary	land 212	201
	Sta Registr		31. Date filed (Monty, Day, Year)	32. Registrar						

			For Americ State Americ Registrar	l Item 2	State of 9d per I	Maryland Dr.,G83	/ Dep:	artment of H	lealth a D <i>eath</i>	nd Ment	al Hygiei	n2004	34712
			1. Decedent's Name (F			FII		1.0			ate of Death	Day Year	3. Time of Death
	Physici /Medic		mar	1 0	S	toke	2					23 2001	121 40PM
	Examin		4a. Fecility Name (If no	t Institution, give	street and numb	er)		4b. City, Town, or	Location of	f Death		4c. County of Death	AI/A
			Bon	Sea	-	tosp	tal	130	4	non	2		NP
	Funeral		5. Social Security Numl	1	x 7. □M 2[X]F	Age (In yrs. la:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (M	ite of Birth fonth, Day, Ye RIL 16	9. Birth Cou	nplace (State or Foreign untry)
	Director		220-20-273 Usual Residence of De			//				AP	KIL 10	,192/	MD
	/land			b. County	1	10c. City,	Town or Lo	ocation					10d. Inside City Limits
	Man 1-1 sh	tor	MD		AIA	BAI	TIMO	RE					1X Yes 2 □ No
	th the	irec	10e. Street and Numbe	or				10f. Zip Code			10g.	Citizen of What Cou	untry?
	23a c	a D	2120 ASHB	URTON S	TREET				1216			USA	
	hours after death with the Maryland tural', or Itams 23a or 28a-1 show at Exertiner must be notified at	Funeral Director	11. Marital Status		12. Was Decede Armed Force	es?	. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig in, Mexican,	jin? (Specify Y Puerto Rican	es or No- , etc.)	14. Race - Amer Black, White	
36	s afte	by Fu	1 ☐ Never Married 3 ☐ Widowed 4 ☐		1 ☐ Yes 2 If Yes, Give Year or Date			1 ☐ Yes 2 🗓 No	Specify:			Specify: BLA	CV
215-0036	hour fural	ed to		. Decedent's Ed		35.	16a. Dece	dent's Usual Occup	ation		16b	DLA D. Kind of Business/I	
15	n "nat	Completed	(Specify of Elementary/Secondary	only highest grad	de completed) College (1-4	07.54\	(Give	kind of work done of DO NOT use retired	during most ()	of working			
212	d within giene. er than "	E O	Elettletitary/Seconda	ary (0-12)	2	0.347	Medi	cal Secr	etary			Healt	h
	be filed tal Hygid d other event, I	Be C	17. Father's Name (First	st, Middle, Last)						r's Name (Firs			
Vla	Ment Ment arked	၉	DANIEL J.	CLASH				,		Z LILLI			
Maryland	2 sho	/ //	19a. Informant's Name	3/Relationship (T	ype, Print)		19b. Maili	ng Address (Street :	and Number Street	-		ty or Town, State, Z	
-	es 1 and 2 of Health a fitem 27 ls r othar tra		JACQUELIN		RD/DAUGH		A. J. 4- 1	Sition (Name of	ON ST	BALT	IMORE,	MD 2121 Location - City or T	6- 21229
Baltimore	Pages 1 nent of t- ant: If ite ary or ot		20a. Method of Disposi	Premation 3 🗆		ate cer	netery, cre	matory or other plac	. 1	10-28-		ROWNSVILLE	
ţ	t. Pa rtmen rtant: njury		°4 □Donation 5			CRO		LLE VET.			-		
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-f show amount injury or other traumatic event, it is Musifical Examinar must be mullified at once.		21. Signatore of Funer	CONTRACTOR CONTRACTOR	1. 1	Jorte	_	2. Name and Addres		JAMES			IS F.H., INC. 21217
	Pnysician /Medical		23a. Part 1. Enter the c shock, or heart fa Immediate Cause (Fin disease or condition resulting in death)	ailure. List only o	a	as a cons que	ec.	ter the mode of dyin	g, such as o	cardiac or resp	uiratory arrest,	200	Approximate Interval Between Onset and Death
8	Examiner.		C	tions	h		W						
} =	p =	ner	Sequentially list condition in the cause. Enter Underlyi	SPECIAL SECTION AND ADDRESS OF THE PERSON AN	Due to (or	as a conseque	ence of						
	icate be executed physician and s the buriat-transit	Examiner	cause. Enter Underlyi Cause (Disease or inju- that initiated events resulting in death) Las	ıry	C	as a conseque							
60,	cate be execu physician and the burial-tra	E E	racening in accum, and		Dua (0)	as a conseque	silve oi).						
8760,	physicate	dical			d					_			
.O. Box 6	that the death certific ted by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent print the past 12 mg 1 Yes 2 N 9 Unknown	Aths?		h 2 ∏ Fetalo nt at time of dea	death 3	□Ectopic pregnancy □ Other (specify)				23d. Date of deliver Month	very Day Year
of Vital Records, P.	es igr	by	Part II. Other significa	nt conditions co	ontributing to dea	th but not resul	ting in the t	inderlying cause giv	en in Part I.	564)	3e. Did tobace	co use contribute to	the cause of death?
Ö		Completed		1+21	vasct	1112	741	dinu	1	2	4a. Was an	24b. Were aut	topsy findings available ompletion of cause of
Re	0 L 0	E O		MI	20 11		01	^			autopsy performed ☐ Yes 2 2	death?	2□ No
ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred	to medical	LVCE	200	-CA		26. Place	of Death (Che			
<u>_</u>	S 5	10	examiner? 1 ☐ Yes 2 ☑ No		Hospital: 1 ☐ Inp	oatient 2 E	R/Outpatie		4 L Nui	rsing Home	Residence	e 6 ☐Other (Spec	ify)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 Natural	5 Pending	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury	Wor			escribe how in	njury occurred	
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Division	or At offer d Direct in by	Certification;	4 Homicide	determined	286. Place 0	f Injury - At hon g, etc. (Specify)	ne, tarm, st	reet, factory, office			ity or Town, S	t and Number or Rui tate)	rai Houle Number,
ū	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	ledical Ce	(Check only 2[niner: On the bas	is of examination						e(s) and manner as and place, and due	
	thin 2, the P the P	Med	one) 29b. Signature and title	e of certifier	and manne	or stated.		29c. Licens	e number		29d.	Date signed (Month	, Day, Year)
	Vith To Con) O	100)	001		11/2	MDI	77	291			
			20 No.	MAC) Y	NOXO	IVV	Prior)	C 10			vember 1,	2004
			30. Name and address	Lat	completed cause	S V S V	l W	T 2	30	0 90	MVE	NONDE	19 SISIR
4	Sta Regist	ate rar	31. Date filed (Month, NOV 0 3	Day, Year) 2004	Sanara Sanara	gistrar's Signatu	Ire						

		-	1 - State of State of Registrer	Maryland / Dep <i>Ce</i>	ertificate of L	ealth and Me Death		2004	34713
			Decedent's Name (First, Middle, Last)		\wedge	2	Date of Death	D. V	3. Time of Death
	Physicia		Reality		Dogar	110 1	etober	Day Year 2004	1 3:45 PM
	/Medic		4a. Facility Name (If not institution, give street and number	per) s	4b. City. Town, or	Location of Death	(,)0001	4c. County of Dea	
	Examin	er		12/201	MIL	11000	$\sum_{i=1}^{n} i ^2$	NT / 70	
			5, Social Security Number 6. Sex 7	Age (In yrs. last birthday	If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	N/A	thplace (State or Foreign
	Funeral		1 □ M 2 🖾 F	0 Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) C	ountry)
	Director	-	213-71-7758 Usual Residence of Decedent	0	Т		SEPT 28	2004 MA	ARYLAND
	and **		10a. State 10b. County	10c. City, Town or I	ocation				10d. Inside City Limits
	lanyl sho	ō	W15775 W157055 G0						1 ☐ Yes 2 💆 No
	he N	Director	MARYLAND HARFORD CO 10e. Street and Number		EDGEWOOD 10f. Zip Code		100	, Citizen of What C	punto/?
	vith t	Ē			111111		100	, Ollizon or What O	ountry :
	ath v	Ta	510 CROWNWOOD CT.	.=	210		N	U.S.A.	rices Indian
	er de	Funeral	Armed Ford	ent Ever in U.S. 13	If Yes, specify Cuba	spanic Origin? (Specil n, Mexican, Puerto Ric	an, etc.)	Black, Whi	
36	orl	by F	1 Xaever Married 2 Married 1 Yes 2		1 ☐ Yes 2ĀNo	Specify:		Specify:	
ö	hours after death with the Maryland tural', or Itams 23e or 28a-1 show al Exatral or must be motified at	q p	3 ☐ Widowed 4 ☐ Divorced Year or Dat				1 40	-1	BLACK
ν.	72 ne	Completed	15. Decedent's Education (Specify only highest grade completed)	(Giv	edent's Usual Occupa te kind of work done of	furing most of working	16	b. Kind of Business	vindustry
21	within ene. than "	du	Elementary/Secondary (0-12) College (1-	for 5+)	DO NOT use retired	,		NT / 7	
7	e filed with at Hygiene other thai	CO	N/A	N/A		18. Mother's Name //	Tona Adiabata Ada	N/A	
힏	be filed tal Hyg d othe evant,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name (F	-irst, Middie, Ma	iden Sumame)	
<u>la</u>		2	JERMARL SESSOMS				SESSOMS		
Maryland 21215-0036	0 0 0	K J	19a. Informant's Name/Relationship (Type, Print)	19b. Mai	ling Address (Street a	and Number or Rural F	Route Number, C	City or Town, State,	Zip Code)
	1 and 2 Health Ism 27 i		Jermarl & Ramona Sessoms/	Parents 51	0 Crewbwoo	d Ct. Edge	wood. M	d., 21040	
<u>e</u>	es 1 a of Hea fitam r othe		Zou. Motified of Disposition	cometani ci	oosition (Name of ematory or other place		9 20	c. Location - City or	Town, State
E C			1 ☐ Burial 2XXCremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Specify)	ate	REMATORY	11-06-	.04 BA	LTIMORE,	MARVI.AND
Baltimore,	permit. Pag Department Important: I any injury o		21. Signatur of Funeral Service Licensee		22 Name and Address	s of Facility			
Ba	permit. Pag Department Important: I any injury o		Marke C.A	W		COMMUNITY			
			23a Part 1. Enter the disease, or complications that ca	used the death. Do not e		LADELPHIA g, such as cardiac or r		,	Approximate
		y I	shock, or heart failure. List only one cause on ea	ch line.					Interval Between Onset and Death
	Priysician		disease or condition resulting in death)	tizing Entero	colitis				2 days
	/Medical Examiner								_ s
	LAGITITIE		Secuentially list conditions	ne Prematurit	у				30 days
	ס ##	lue	cause. Enter Underlying Cause (Disease or injury that initiated events c.	r ss.a.consagrience of):					
	nd rrans	Examine	Cause (Disease or injury that initiated events c.						
oʻ	e exe		resulting in death) Last Due to (d	r as a consequence of):					
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dlcal	d						
9	tifica ng ph as th	led	Treesing .						
Вох	leath certific attending p I for use as	Z.	23b. was decedent pregnant	ome of pregnancy th 2 Fetal death 3	☐Ectopic pregnancy			23d. Date of de	
8	deatl	icia	in the past 12 months? 1 Ves 2 No. 4 Pregna	nt at time of death 5	Other (specify)			Month	Day Year
0	that the de ned by the a detached t	Physician/Me	9 □ Unknown 9 □ Unknown	٧n					
σ.	es thai igned t be det	by P	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
p	uires n sign ld be	d b					1 ☐ Yes	2√2 No 3□P	robably 4 Unknown
Records,	w requir been si should	Completed					24a. Was an	24b. Were a	utopsy findings available
Re	ne lav has ge 2	g L					autopsy performe	death?	completion of cause of
a	ician: Th certificate rector, pag		Of Managed to modical				1 Yes 2		2 200
of Vital	Physician: this certificant director,	Be	25. Was case referred to medical examiner?		ont 2CI DOA Othe	26. Place of Death (
of	Phys this al di	2	1 Yes 2 No 11 In 127. Manner of Death 28a. Date of	patient 2 ER/Outpati	ent 3 DOA	4 Nursing Home		ce 6 Other (Speningury occurred	эспу)
	ding for Atter tuner	lo	1 Natural 5 Pending (Month	, Day Year) Injury	Work	<br Yes 2 □ No		injury december	
sio	vttendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be				Langting (Ctro	at and Number of E	turni Bouto Alumbos
Division	for Attencater death Director:	Certification:	determined 286. Place	of Injury - At home, farm, : g, etc. <i>(Specify)</i>	street, factory, office	28	City or Town,	et and Number or R State)	urai Houte Number,
Ω	ital c								
	dosb t hou una ely fil	cal	29a. Certifier Check only Check only						
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	Medical	one) and mann						
	To To	2	29b. Signature and title of certifier		29c. License			I. Date signed (Mon	
,			Janual & Bullen MD		RE	S-000		October 28	, 2004
1/4			30. Name and address of person who completed cause				_		
r)		Janine E. Bullard, MD 600 No.	th Wolfe Street	; Baltimore	e, MO 2128	7		
	St	ate	and the same of th	gistrar's Signature					
	Regist	rar	NOV 0 3 2004	news &	Sporks	/			

			For Stete Registr <i>e</i> r	State of Mary	land / Depai <i>Cert</i>	tment of F <i>ificate of</i>	lealth and M <i>Death</i>		jier (20) () (eg. No.	34714
	Dhysisi		1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dear Month		3. Time of Death
	Physicia /Medic		RUBY M. SCHWAI					10	30- 20	004 5 4.M.
	Examin	er	4a. Facility Name (If not institution, gr			4b. City, Town, o	or Location of Death		4c. County of	
				Sex 7. Age In	yrs. last birthday)	If Under 1 Year	DALE If Under 24 Hrs.	8. Date of Birth	DHL	Birthplace (State or Foreign
	Funeral Director		111-12-5602	1 TH OME		Months Days	Hours Min.	8. Date of Birth (Month, Day)	18 E	Country) CNGLAND
	ס		Usual Residence of Decedent					37 177	10	
3)	arylar show	_	10a. State 10b. County		c. City, Town or Loca				7	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
~	he Mi	ecto	MD BALTII	MORE	PERRY H.	ALL 10f. Zip Code			0g. Citizen of Wh	
	with the same	Dir	5020 TARTAN H	TII DUVD			128	'	USA	at Country!
	death with the Maryland ms 23a or 28e-f show must be invilled at	Funeral Director	11. Marital Status	12. Was Decedent Ever	in U.S. 13. W	I	L Z O Hispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No-	14. Race -	American Indian,
-9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	1	res, specify Cub: ⊒Yes 2.728 No	an, Mexican, Puerto Specify:	Hican, etc.)		White, etc.
5-0036	hours tural', d	d by	3 ₩Widowed 4 Divorced	Year or Dates:					Specify:	WHITE
- 17	"natu	Completed	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Decede (Give ki	nt's Usual Occup nd of work done O NOT use retire	pation during most of worki d)	ing	16b. Kind of Busin	ness/Industry
2121	filed within Hygiene. Ither than "	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		OMEMAKI			НОМ	IE.
	~ - 0 =	a	17. Father's Name (First, Middle, Las	st)			18. Mother's Name	(First, Middle, I		
<u>a</u> ≥	should be id Mental marked o	To B	RUBE WOLMA	N			NETTI	E KERR	IGAN	
$dash$ $ec{ec{ec{N}}}$ Maryland	2 P B 12 B		19a. Informant's Name/Relationship			•	and Number or Rura			. , ,
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 and Health Iem 27 other tr		MRS. ARLENE LI		ER 5020				RY HALL 20c. Location - Ci	
_) §	Pages 1 nent of H int: If ite iry or ot		1 Burial 2 ☐ Cremation 3	Removal from State M	I KROWKOI		eth			
Baltim			' 4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic			EMETERY Namezandraedus			BALTIMO	
Ba	permit. Departr Importa any inju		PRIA R	DAM			VSK ^F I ^{cilit} FUNI IDALK AVI			
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that caused the						Approximate Interval Between
الم	Physician	e i	Immediate Cause (Final disease or condition	A 2112	te M	1100	ARdia	1 Tal		Onset and Death
7	/Medical		resulting in death)	a or as a co	nsequence of):		1 - 01.5		4.010	10/113
- 8	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. Aorti	05	lenos	515			
	led isit	Examiner	Cause (Disease or injury	Due to (or as a cor	nsequence or):					
	axecul and and al-tran	xar	that initiated events resulting in death) Last	c Due to (or as a cor	nsequence of):					
8760,	icate be executed physician and s the burial-transit	edical		d						
9		Nedi	IF FEMALE:							
Вох	eath certific attending pl	an/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐	Fetal death 3 □E	ctopic pregnancy	y		23d. Date of	
	at the dea by the al stached fo	Physician/M	1 Yes 2 No	4☐Pregnant at time 9☐ Unknown	of death 5 🗌 (Other (specify) _			l literature	, Day
P.0	The law requires that the death certif Ite has been signed by the attending vage 2 should be detached for use a		Part II. Other significant conditions	contributing to death but no	t resulting in the unc	erlying cause gru	ven in Part I.	23e. Did tot	pacco use contribu	ute to the cause of death?
ds,	w requires that s been signed b should be deta	d by						1 □ Ye	es 2 2 No 3	☐ Probably 4 ☐Unknown
Ö	s beer shou	Completed						24a. Wasa		re autopsy findings available
Re	The law cate has	omi						autops perform	ned? dea	or to completion of cause of the later of th
ita		Be C	25. Was case referred to medical examiner?				26. Place of Death			
> >	Physic this ce al dire	Lo	1 ☐ Yes 2 ☑ No		2 ER/Outpatient	3□ DOA O#	4 Nursing Ho		ence 6 Other	(Specify)
u o	ding P. h. After t funera	ion:	27. Manuar of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time of Injury	28c, Injur		28d. Describe ho	ow injury occurred	
Division of Vital Records,	death death stor: ,	icat	2 Accident investigate 3 Suicide 6 Could not	be 280 Place of Injury	At home farm stree		Yes 2 □ No	28f. Location (St	reet and Number	or Rural Route Number.
Div	after Direction by	Certification:	4 ☐ Homicide determine	building, etc. (S)	pecify)	st, factory, office		City or Towr		
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certifying (Check only one) 2 Medicel Ex	Physicien: To the best of my eminer: On the basis of exa	y knowledge, death omination and/or inve	occurred at the til stigation, in my c	me, date and place, a	and due to the ca	ause(s) and mann ate and place, and	er as stated. If due to the cause(s)
	o the ithin 2 o the omplel	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	2	9d. Date signed (/	Month, Day, Year)
	F 3 F 8		1 XYA	M	Resident H.D	Rad	00000	0	10/2-	14
	X		30. Name and address of person wh		(Item 23a) (Type, P	rint)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		10/30	
:1	Ψ `		De. Lois Pete	15-9000 Fray	uKlin50	MARED	eive Bal	timore,	MD.21	237
	Sta Registr		NOV 0 3 2	32. Registrar's S	Signature &	Son &		,		

		-	1 - State of Maryland / Registrer	Department of Hea Certificate of Dea	lth and Menta ath	Al Hygien	2004	34715
	Physicia		1. Decedent's Name (First, Middle, Last) Walter J. Strycharz	, Sr.		onth, Daniel Di	₿1, ŽÖO	3. Time of Death 4 11:35AM.
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Johns Hopkins Bayview Med. (c. County of Deat	h
	Funeral Director		5. Social Security Number 217-22-0243 6. Sex 1 M 2 F 7. Age (In yrs. last to 77		Under 24 Hrs. 8. Date ours Min. Jan	te of Birth Onth, Day, Year 122,192	27 Mar	nplace (State or Foreign untry) yland
	Maryland	tor	, , , , , , , , , , , , , , , , , , , ,	imore, MD				10d. Inside City Limits 1
	with the	Director	10e. Street and Number 3705 Mt. Pleasant Avenue	10f. Zip Code 21224			itizen of What Co	untry?
စ္	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than 'natural', or liems 23a or 28a-f show marked other than 'natural' or liems 23a or 28a-f show maric event, the Madical Evanthar maric event, the Madical Evanthar maric event.	Funeral	11. Marital Status 1 □ Never Married 2 Married In U.S. Armed Forces? 1 □ Never Married 2 Married If Yes 2 Married If Yes 2 Married If Yes 3.	13. Was Decedent of Hispar If Yes, specify Cuban, M	nic Origin? (Specify Yelexican, Puerto Rican,		USA 14. Race - Ame Black, White	e, etc.
Maryland 21215-0036	in 72 hours "natural", edical Eva	Completed by	3	Sa. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired)	1	16b. '	Specify. Whi Kind of Business/	te Industry
212	ed withing ygiene.	Comp		Supervisor	Mother's Name (First,		per-Eas	tern
land	id be fill lental H ked oth ic even	To Be	17. Father's Name (<i>First, Middle, Last</i>) Joseph Strycharz		ntoinette		en Sumame)	
Mary	es 1 and 2 should b of Health and Menti fitem 27 is marked r other traumatic e			9b. Mailing Address (Street and 1705 Mt. Pleas				
altimore,	ages 1 ar ent of Hea nt: If item 3 y or other			of Disposition (Name of tery, crematory or other place)	Date 11-4-04		Location - City or ltimore	
Baltii	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Sovice Licensee	22. Name and Address of 1201 Dundal	FacilitKaczor	owski	Funera	1 Home, PA
			23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line. Immediate Cause (Final			ratory arrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		Due to (or as a consequence	Fibrillation e of): Heart Failure				30 hrs
	\$	ner.	Sequentially list conditions, b. Clue to (or as a consequence of any, leading to immediate					10 yrs
, , ,	cate be executed bhysician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	TESSUTE te of):				30 yrs
68760,	ificate b g physic as the b	edical	d					
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 9 ☐ Unknown				23d. Date of del Month	ivery Day Year
	puires that the signed by ald be detacted		Part II. Other significant conditions contributing to death but not resulting Diabetes, Coronary Artery Diabetes		Part I. 23	3e. Did tobacco		othe cause of death?
Division of Vital Records,	The law requii sate has been s page 2 should	Completed by				ia. Was an autopsy performed?	prior to death?	itopsy findings available completion of cause of
Vital	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/	Other	Place of Death (Chec		6 DOther (See	oif d
on of	ding Phys h. After this funeral di	tlon; To	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28t	b. Time of Injury at Work?		escribe how inj		city)
Division	I or Attending I after death. Director: After	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	farm, street, factory, office		cation (Street a ty or Town, Sta		ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowled condition and manner stated.					
•	To th within To th	Me	29b. Signature and title of certifier	Res.	mber - 000	29d. D	Date signed (Mont	h, Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23)	a) (Type, Print)	Morl (+4	Ra	Homoso	MD
	Sta Regist		31. Date filed (Month, Day, Year) NOV 0 3 2004 32. Registrar's Signature	Res. A) (Type, Print) H Bayview A Sports	4u. ur.	. <u>U</u>	.,,,401	
	ricgist	A.I.	7	" Laboration of				

			For State Registrar	State of Maryland / Department of Health and Mental Hygiene 0 14 347							
			Decedent's Name (First, Middentification)	lle, Last)					eath	3. Time of Death	
	Physici /Medic		Esther	Ir	Irene		Thomas 4b. City, Town, or Location of Deat		er 18 2	004 12:05a M	
>	Examin	i	4a. Facility Name (If not institution, give street and							4c. County of Death	
			3227 Carlswo	ood Circle		Wood1					
	Funeral		5. Social Security Number	6. Sex 7 1 ☐ M 2 🛱 F	Age (In yrs. last birtho	Months Days			ay, Year)	Birthplace (State or Foreign Country)	
	Director		220-18-7273 Usual Residence of Decedent	- X	81 Yrs	b.		03 0	4 23	MD	
	land Dw		10a. State 10b. Count	у	10c. City, Town o	r Location				10d. Inside City Limits	
	Mary -f sh fied	ţō	MD NA		Baltim	ore				M Yes 2 □ No	
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?	
	h with		3227 Carlswoo	od Circlo		212	11		U.S	7	
	deat	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U.S.	13. Was Decedent of If Yes, specify Cu		(Specify Yes or N		- American Indian, k, White, etc.	
36	72 hours after deeth with the Maryland neturel; or Items 23a or 28a-f show alsa Examiner must be nailfied a	by Fu	1 ☐ Never Married 2 🙀 Ma 3 ☐ Widowed 4 ☐ Divorce	rried 1 □ Yes 2√1 If Yes, Give]No	1 ☐ Yes XXN		, , , , , , , , , , , , , , , , , , ,		Black	
21215-0036	"neturel",	Completed I	15. Decede	nt's Education	16a. De	ecedent's Usual Occi	upation	onkina	16b. Kind of Bus		
2	i within 72 ho jene. r than "netu ir e Medical	nple	Elementary/Secondary (0-12)	College (1-4c	- lii	e. DO NOT use retir	ed)	orking .			
	filed w Hygien ther th	Co	12th grade	4yrs		Analyst				o Oil	
<u>n</u>		Be	17. Father's Name (First, Middle	, Last)			18. Mother's Na	ame (First, Middle	e, Maiden Sumame	a)	
Z	2 should and Mer Is marke sumatic	2	Jarvis H. La					ne Tho			
Maryland			19a, Informant's Name/Relation			ailing Address (Stree			·		
	1 and Health em 27 ther tr		Alfred Thoma	as-Husband		27 Carls sposition (Name of	wood Ci	rcle,		n Md 21244 City or Town, State	
Baltimore,			1 Burial 2 Cremation	3 □Removal from Sta	te cemetery,	crematory`or other pl	.			•	
臣			* 4 Donation 5 Dother (Woodla		_	22/04	Baltim	ore Co, Md	
Bal	permit. Departr Importa any inju		21. Signatura a Funda ervice	Licensee V.	2000	22. Name and Add March F/	H West				
			23a Part1 Enter the disease of	or complications that cause	ed the death. Do not	4300 Wab	oash Ave	Balt.	imore,	Md 21215 Approximate	
	Physician /		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heart failure. List only one cause on each line. Immediate Cause (Final								
7			disease or condition resulting in death) a. "LyoChullal cuffunts"								
	Examiner			Due to (or/s	as a consequence of):	0	01	dia		220ms	
L.		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	as a consequence of):	erona) Cura) original	au .	POS	
	cate be executed physician and the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	1 Her	seehenson	·					
Ć	be executed ician and burial-transi	Еха	resulting in death) Last	Due to or a	as a consequence of):						
8760,	cate be physicia the but	dicai		d							
9	tifica ng ph as th	0	1								
Вох	the death certific y the attending p sched for use as i	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth		3 □Ectopic pregnani	cv			of delivery	
	ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of death	5 Other (specify)			Moni	th Day Year	
P.0	at the de d by the a stached	Phy	9 Unknown								
	The law requires that ite hes been signed b page 2 should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown		
Records,		ompieted						10	Yes 2 No	3 Probably 4 Unknown	
ec	e law hes b	npie						24a. Was	psy pr	ere autopsy findings available ior to completion of cause of	
	Physicien: The this certificate he ral director, page	Con	performed? death? 1 Yes 2 No 1 Yes 2 No								
Vital		Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one)								
of	this aldii	L 2	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
n C	fter fen	lon	27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred								
Sic	Attending r death. sctor: Afte by the fune	icat	3 ☐ Suicide 6 ☐ Could		Diugra At home farm		Yes 2 No	28f Location /	Street and Number	r or Rural Route Number.	
Division	al or Attendii after death. I Director: A d in by the fu	Certification;	4 ☐ Homicide determ	building,	etc. (Specify)	y - At home, farm, street, factory, office (Specify) 28f. Location City or 1			Town, State)		
	To the Hospital or I within 24 hours after To the Funerel Direct completely filled in b		29a. Certifier (Check only Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
	the H in 24 the F the F	Medical	Une,	and manner	stated.						
	7 × 10 × 10 × 10 × 10 × 10 × 10 × 10 × 1	2	29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)								
	1		flying in		Mice).	026	880		11/1/04	(
	n		30. Name and address of person	who completed cause o			10 3 A	ml.	00001		
	4 A C		31. Date filed (Month, Day, Year	-VV-3 320 AV	mory Store strar's Signature	e oute.	oc self	ma.	11 101		
	Sta Registr	-	NOV 0		ar a Mariaria	1 0					
	MH 17 Rev 1/2		NUV ()	3 ZUU4 1 70	enewa /	e Sufe.	6/				
DH	VID 17 DEV 1/21			*	•		1000				

			For Stata Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of H <i>tificate of L</i>		-	giene 0 ()4 34717
	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last) William E. Ta 4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		2. Date of De Month Octobe	ath Day	Year 004 8:25 PM ^M f Death
	Funeral		Keswick Multicare 5. Social Security Number 219-07-3541	7. Age	ə (İn yrs. last birthday) Q7 Yrs.	Balt If Under 1 Year Months Days	imore If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da	th y, Year)	9. Birthplece (State or Foreign Country)
	Director works	or	Usual Residence of Decedent 10a. State		10c. City, Town or Lo Baltime			April 3	30,1917	Maryland 10d. Inside City Limits 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Marylod Extra instruments and the rediffed at	Funeral Director	10e. Street and Number 4300 Newport Avenu	2. Was Decedent		10f. Zip Code	211 spanic Origin? (S		10g. Citizen of Wi	hat Country? - American Indian,
-0036	72 hours after o "natural", or iter	ted by Fur	1 Never Married 2 A Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	WWII	1 ☐ Yes ŽŽŽ No	Specify:		Specify:	, white, etc. White
Maryland 21215-0036	lled 1ygi ther nt, 1	e Completed by	(Specify only highest grade Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	completed) College (1-4or 5	+) life. I	kind of work done of DO NOT use retired Repair Pe	rson	·	Gas & E1	ectric Co.
larylan	should be and Mental is marked o	To Be	William Raymon	oe, Print)		ng Address (Street a	and Number or Ru		er, City or Town, S	
	호등 전 노		Ethlyn M. Tarr 20a. Method of Disposition 1 \(\mathbb{\text{\text{Specify}}} \) 4 \(\mathbb{\text{Opnay}} \) 5 \(\mathbb{\text{Other}} \) (Specify)	Wife emoval from State	20b. Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - C	ryland 21211 ity or Town, State 1e, Maryland
Balti	permit. Pages 1 a Department of He- Important: If item any injury or othe		21. Signatur Funeral Service License	Hen	38 B	Name and Address Irgee-Hen 31 Falls	ss of Facility SS-Seitz Road, Ba	Funeral altimore	Home, I Maryla	nc. 21211 nd
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Lemle	the death. Do not ent	4 71	y Lewer	a	rrest,	Approximate Interval Between Onset and Death
8760,	cate be executed by physician and into burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence of): a consequence of):					
O. Box 6	The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	
Δ.	v requires that been signed b should be deta		Part II. Other significant conditions cor	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	/	oute to the cause of death? Probably 4 Unknown
of Vital Records,		Completed by							osy pri rmed2 de 2 No 1	ere autopsy findings available for to completion of cause of ath? Yes 2 No
	ding Physici h. After this cer funeral direct	atlon: To Be	27. M vn; of Death 1 Latural 5 Pending 2 Accident investigation	ospital: 1 ☐ Inpatie 28a. Date of Inju (Month, Da	1	28c. Injury Work	4 Drivursing H	ome 5 🗆 Resid	n <i>e)</i> dence 6 □Other now injury occurred	
Division	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	building, et				City or Tov	vn, State)	or Rural Route Number,
	To the Hospital within 24 hours a Yo the Funeral Completely filled	Medical	29a. Certifier 1 De Certifying Physical (Check only one) 2 Medical Examinate Medical Examinate of Certifier 1	ner: On the basis of and manner sta	of my knowledge, death examination and/or in- ited.	vestigation, in my op	pinion, death occu	rred at the time,	date and place, and manidate and place, and 29d. Date signed (d due to the cause(s)
)	1X \		30. Name and address of person who co	mpleted au r of d	eath (Item 23a) (Type,	D 3 ()433	0.	007 29	, 2004
	Sta Registr		31. Date filed (Month, Day, Year)	MCV 6	70 N	CMMU.	S 87	131	VIIMOR	5 21204

DHMH 17 Rev 1/2001

			1- For Amend Item Registrar	State o	f Marylar anatomy	nd / Depa board	ertment of l C337 11 tilicate of	Health a	and Mental H tas	ygiene	1004	34718
	.		1. Decedent's Name (First, Middle,						2. Date of D	Death		3. Time of Death
	Physici /Medi		Carroll Lee Ut	z					Octob	er 20,	2004	7:30 AM M
	Examir		4a. Facility Name (If not institution,	•	mber)		4b. City, Town,	or Location o	of Death	4c. C	County of Deeth	ו
			5903 Eric Driv				Mt.				arrol1	
۲	Funeral Director		5. Social Security Number 216-38-3034	3. Sex 1)X) M 2 □ F	7. Age (In yrs.	65 Yrs.	Months Days				001	nplace (State or Foreign untry)
			Usual Residence of Decedent		70	45			Feb 1:	3, 193	4 Mary	yland
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
	B Ma	cto	MD Carro)11		Mt.	Airy					1 ☐ Yes 2√∑ No
	ith th	Dire	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	intry?
	23a	Funeral Director	5903 Eric Driv					21771			USA	
	item item	une	11. Marital Status 1 ☑ Never Married 2 ☐ Marrie	Armed Fo		I.S. 13. V	Vas Decedent of I Yes, specify Cub	Hispanic Orig an, <mark>Mexi</mark> can	gin? (Specify Yes or N , Puerto Rican, etc.)	No- 14	 Race - Amer Black, White 	
336	irs aff	by F	3 ☐ Widowed 4 ☐ Divorced	d 1 □Yes If Yes, Giv Year or D	/e **	1	☐ Yes 2X No	Specify:		s	Specify: wh	ite
21215-0036	be filed within 72 hours after death with the Maryland Ital Hyglene. Id Hyglene. d other than "natural", or items 23e or 28e-f show event. The Medical Examinar must be notified at		15. Decedent's	Education			ent's Usual Occu			16b. Kind	of Business/li	ndustry
215	thin 7	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	kind of work done OO NOT use retire	during most id)	of working			
2	e filed within al Hygiene. I other then " vent. Ins Me	Con	12			te	eacher				cation	
Maryland	be fill H ad out	Be	17. Father's Name (First, Middle, Li Charles Edward	•					r's Name (First, Middl	le, Maiden S	u <i>mam</i> e)	
7	d 2 should be th and Mental ?7 is marked o traumatic sve	ပ	19a. Informant's Name/Relationshi			105 14-11-	- Add (Ct		adys Otto			
Ma	d 2 : h ar h ar 7 is trau		Maggie Utz/sis		17.7				r or Rural Route Num			
ē,	s 1 and 2 f Health item 27 i		20a. Method of Disposition	CCI III IC	20b. P	Place of Dispos	sition (Name of		ad Union B		MI) 2	
Ë	Page: ent of nt: If I		1 ☐ Burial 2 ☐ Cremation 3 1 ☐ Burial 2 ☐ Cremation 3	acifu)	State	-	natory`or other pla	ce)			,	
Baltimore,	permit. Pages Department of I Importent: If its any injury or of	ì	21. Signatur 1 Funeral Scribe Li	censee Wade, p	itector	S.E.	Name and Addre ate Anat	ess of Facility	y Dard 655 W.	. Balt	imore 9	Stroot
	40244	Н	1	1 (11	المالية	ра	ltimore,	MD 2	gard 655 W.	· Buic	IMOTE L	
1			23a. Paril . Enter the disease, or conshort, or heart failure. List or	nly one cause on e	aused the deat ach line.	n. Do not ente	ir the mode of dyl	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		emmonia							1 week
	Examiner				or as a conseq		2					Δ. 14
1		e	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a curiseq	uence oi):	(wager	anen)			8 months
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c								
ő,	the death certificate be executed y the attending physician and iched for use as the buriat-transit		resulting in death) Last	Due to (or as a consequ	uence of):						
8760,	cate b	dical		d								
9 x 6	death certifica attending ph for use as t	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregna	ancv				- I		
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live b	irth 2 ☐ Fetal	death 3	Ectopic pregnancy Other (specify)	<i>,</i>		230	d. Date of deliv Month	ery Day Year
o.		hysi	9 Unknown	9□ Unkno	own					-		
O.	requires that een signed b hould be deta	by P	Part II. Other significant condition	s contributing to de	eath but not resi	ulting in the un	derlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
ord	w require been sig should b								1	Yes 2□	No 3 ☐ Prot	pably 4 Dunknown
Records,	law as b	Completed							24a. Was		24b. Were auto	opsy findings available impletion of cause of
<u>=</u>		Son								ormed? 2 No	death?	2 No
Vital	Physician: This certifical director, p	Be	25. Was case referred to medical examiner?	Manaitali					of Death (Check only			
of	shys this	10	1 Yes 2 No 27. Manner of Death		npatierit 2				sing Home 5 Res			(y)
on	ding F h. After funera	tlon	1 ☑Natural 5 ☐ Pending		of Injury h, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ N	28d. Describe	now injury o	ccurred	
Division	deal deal	fica	3 Suicide 6 Could no	the -	of Injury - At ho	ome, farm, stre		163 2 16		(Street and N	lumber or Rur	al Route Number.
ā	rs after el Dire ed in b	Certification:	4 Homicide determine	buildir	ng, etc. (Specify	y)	et, factory, office		City or To	wn, State)	2.7.00	arriodio ramber,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the ba and mann	isis of examinat	wledge, death tion and/or inv	occurred at the tirestigation, in my o	πe, date and pinion, death	place, and due to the n occurred at the time,	cause(s) an	d manner as s ace, and due to	tated. o the cause(s)
	To th within To th compi	Me	29b. Signature and title of certifier				29c. Licens	e number		29d. Date s	igned (Month,	Dey, Year)
)			h. Guestan	Dayle "	247)		D2	3809		Octob	en 28,	2004
	i a		30. Name and address of person wh			23a) (Type, F	rint)			A 01		
			L. Aueta Dayle		nelsaum			.2 5. (Treene St.,	Bellyn	nore / mi	21201
	Sta Registr		31. Date filed (Month, Day, Year)	1	egistrar's Signal	ture	backs					
		- 3	NOV 0 3 200	As he was	1	Mark Jes	4 JURICA					

DHMH 17 Rev 1/2001

			State of Maryland / Depa	rtment of Health and Me	•	•	
				tificate of Death	Reg. 1		
	o Dhariai		Decedent's Name (First, Middle, Last)	2	2. Date of Death	2004	3 Time of Peath
	Physicia /Medic		CHRISTINA VESTLING		CloBCK:	29 2004	1245P M
)	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	•	4c. County of Death	
	Funeral	.*.:	Howard County General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Columbia If Under 1 Year If Under 24 Hrs. 8	B. Date of Birth	Howard 9. Births	place (State or Foreign
	Director		341-38-2953 1 M XXF 90 Yrs.	Months Days Hours Min.	(Month, Day, Yea		berth, PA
	pu 🔹		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc				Od. Inside City Limits
	Maryla f sho	ō	Howard Columbia	anon			1 ☐ Yes 2 No
	r 28a-	irect	MD HOWAI'U COLUMBIA 10e. Street and Number	10f. Zip Code	10g. (Citizen of What Cour	41
	th with	Funeral Director	5400 Vantage Point Rd. Apt.503	21044	τ	JSA	
	tems tems	une	11. Marital Status 12. Was Decedent Ever in U.S. 13. Warned Forces? 13. Was Decedent Ever in U.S. 15. Was Decedent Ever in U.S	Vas Decedent of Hispanic Origin? (Speci Yes, specify Cuban, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Americ Black, White,	
36	ırsafte II,orl	by F	1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No If Yes, Give 1 3 ሺ Widowed 4 □ Divorced Year or Dates:	☐ Yes 2XNo Specify:		Specify: W]	hite
9	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show the Medical Exactiver must be notified at	ted	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give k	ent's Usual Occupation kind of work done during most of working IO NOT use retired)	16b.	Kind of Business/In	dustry
7	vithin 7 ne. han "r	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		-		
7	be filed wital Hygier of other the event, In		5+ Libra 17. Father's Name (First, Middle, Last)	arian 18. Mother's Name (i		lucation	
Maryland 21215-0036	d be f ental h ked of c eve	To Be	Arthur John Meredith	Josaphin			ate
ary	should ind Men s marke umatic	-		g Address (Street and Number or Rural F			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Importent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			Littledale Rd.,	Kensin	gton, MI	20895
Baltimore,	Pages 1 nent of He nnt: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, crem.	ition (Name of Dat atory or other place)	te 20c.	Location - City or To	own, State
Ħ.	t, Pag rtment rtent: njury		`4 □Donation 5 □Other (Specify) Baltimore/Wa	shington Crem, Nov.3, 2	2004 La	urel, MD	
Ba	permit. Departr Importe any Inj		21. Signature of Funeral Service Licensee 22.	Name and Address of Facility Witz	ke Fune	raL Home	es, Inc.
			23a. Part I. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line.	555 Twin Knolls or the mode of dying, such as cardiac or r	RO, COTU respiratory arrest,	mbia, Mo	Approximate
	Pnysician :		Immediate Cause (Final disease or condition				Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):				
	Examiner	بين	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	FAILURE			MONTH
13	rted nsit	mine	cause. Enter Underlying Cause (Disease or injury				
ر. م	te be executed ysicisn and te burial-transit	Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):				
3760,	a % a	cai	d				
x 68	Physicien: The law requires that the death certifica this certificate has been signed by the attending phraid director, page 2 should be detached for use as the	/Med	IF FEMALE:				
Вох	eath c attend for us	cian	in the past laborates?	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year
P. O.	the d	hysi	1 Yes 2 No 9 Unknown	~~~			
	es that igned b	by Physician/M	Part II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e. Did tobacco	o use contribute to the	ne cause of death?
ord	v requires been sign should be	ted	RENALFAILURE		1 Tes	2 □No 3 □ Prob	ably 4 Unknown
Sec.	elawı hasbo e2sh	Completed			24a. Was an autopsy	prior to con	psy findings available mpletion of cause of
a	sicien: The law s certificate has b lirector, page 2 s		Of Was are affected by a final		performed?	death?	2□ No
Division of Vital Records,	/sicien s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No Hospital:	26. Place of Death (c		6 ☐Other (Specif	v)
סר	ding Phys		27. Manner of Death 28a. Date of Injury 28b. Time of		d. Describe how in		//
Sior	endin eath. or: Af the fur	catic	2 Accident investigation	M 1 Yes 2 No			
Ξ̈́	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)	et, factory, office 28t	f. Location (Street City or Town, Sta	and Number or Rura ate)	I Route Number,
	spitel ours a nerel l		29a. Certifier Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, an	d due to the cause	(s) and manner as st	ated
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invegore)	estigation, in my opinion, death occurred	at the time, date a	nd place, and due to	the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. D	Date signed (Month,	Day, Year)
			· M · mo	D 50778	Oct	ofer 31	2004
	20		30. Name and address of person who completed cause of death (Item 23a) (Type, P	PSO 778	TPKWY.	CoLum	BIA, MD
*	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	Sparks			21044

			1 - For State Registrar	State of M	laryland / [Depa <i>Cer</i>	rtment of H	ealth an Death	d Mental Hy	giene () Reg. No.	04	34720
	Physicia		1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	Day	Year .	3. Time of Death
Į	/Medic		Catherine	J		4	Jilson		10 -	25-2	2004	6:56 AM
9	Examin	er	4a. Facility Name (If not institution,				4b. City, Town, or		Death	4c. Cour	ity of Death	
			University of Ma						New Year			
	Funeral			. Sex 7. A 1 M 2 F	ge (In yrs. last bin 57	Yrs.	If Under 1 Year Months Days	Hours !	Min. (Month, Da	y, Year)	Coun	
	Director	}	564 67 7244 Usual Residence of Decedent	A					May 29	, 1947	Liber	1a
	iand ow	1	10a. State 10b. County		10c. City, Town	n or Loc	ation				11	0d. Inside City Limits
	Mary -f sh	to	Maryland Howard		Col	umb	ia					1 ☐Yes 2 ☐ No
	r 28a	ec	10e. Street and Number			umb.	10f. Zip Code			10g. Citizen o	f What Coun	try?
	h wit	E D	5867 Harpers Far	m Road			210	44		Liber	ia	
	72 hours after death with the Maryland naturel; or Items 23s or 28s-f show dical Examinar must be notified at	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. W	/as Decedent of His	spanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. R	ace - Americ lack, White,	
9	or It	F.	1 Never Married 2 Marrie				_	Specify:	20/10 / 110211/ 010.7		ify: Blac	
8	urel',	d by	3 Widowed 4 Divorced	Year or Dates:								
7	"nati	Completed	15. Decedent's (Specify only highest		16a.	(Give I	ent's Usual Occupa rind of work done d O NOT use retired	uring most of	working	16b. Kind of	Business/Ind	lustry
12	withir ane. then	d l	Elementary/Secondary (0-12)	College (1-4or			r Worked			N/A		
2	filed within Hygiene. Ither then "		17. Father's Name (First, Middle, La	est)	N	eve.	L WOIKEU	18. Mother's	Name (First, Middle,		ame)	
Maryland 21215-0036	12 should be filed within "h and Mental Hygiene." 7 Is marked other then "iraumatic event, Iha Mer	To Be	Thomas Howard						zelyna Cru		,	
Z	shoul nd M marl	F	19a. Informant's Name/Relationshi	o (Type, Print)	19b	. Mailin	g Address (Street a	nd Number o	or Rural Route Number	er, City or Tow	n, State, Zip	Code)
	1 and 2 Health a tsm 27 Is	00000000	John H. Wilson,	III/son	11	399	Columbia	Park	#D7 Silve	r Spri	ng, MD	20904
Je,	S = = 0		20a. Method of Disposition		nomata:	Dispos	ition (Name of atory or other place	»)	Date	20c. Location	n - City or To	wn, State
Ĕ	Pages nent of h ant: If its arry or o'		1 □ Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Spe		Locust				11-13-2004			
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Li	ensee	101				Marshall's			
_	20 F 9 9		Pinner, 1	Varre		4	308 Suitl	and Ro	oad Suitla	nd, MD	2074	6
	Pnysician /Medical Examiner	her	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	a. Hand Due to (or a	s a consequence	ot):	sith Co	mpli	cations	Circo de la companya della companya de la companya de la companya della companya	Jun 19	Onset and Death Z WICS
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	С.					Via	EXP		
o,	cate be executed physicien and the burial-transit	Ex	resulting in death) Last		s a consequence	of):		.,2	OVED BY M , LAL			
8760,	ate b hysic the bu	dicai		d				1	A OVER		_	
Box 6	ath certifi attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No		e of pregnancy 2 □ Fetal death at time of death		Ectopic pregnancy Other (specify)	CERTIFICATI			Date of delive Month	ry Day Year
P.0	that the de led by the a detached	Phy	9 Unknown		hank mak an anakima da	- 41	4. 4. 1	. i. D. Al	ODo Diela			e cause of death?
	w requires that been signed should be det	by	Renal Far	luve	but not resulting in	n ine un	derlying cause give	n in Part i.		Yes 2 □ No		V
of Vital Records,		Completed									prior to con death? 1 X Yes	osy findings available inpletion of cause of 2 No
/ita	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	Tre-sur					Death (Check only o	ne)		
of	Physic this c	^o	1 Nes 2 No	Hospital:			3 □ DOA Othe	4 Nursii	ng Home 5 Resid)
	ding P. h. After funera	lon	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of In (Month, D		Time of njury	28c. Injury Work		28d. Describe			
Sic	Attending ir death. ector: Afte by the fune	icat	2 Accident investiga 3 ☐ Suicide 6 ☐ Could no	t be	1	Know	-	es 2 No	1 101 (1	Street and Num	alls	Pouto Number
Division	or A	Certification:	4 ☐ Homicide determin	ed 289. Place of It	njury - At home, fa etc. (Specify) 58	67	Harper For	m Rd	City or To	wn, State) 5	867 H	Route Number,
-	spital ours nerel filled		29a. Certifier 1 Certifying	Physician: To the bes		death			lace, and due to the		nanner as st	
	s Hos 24 h s Fur letely	edical	(Check only 2 Medical E. one)	kaminer: On the basis and manners	of examination an	d/or inv	estigation, in my op	inion, death	occurred at the time,	date and place	e, and due to	the cause(s)
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Me	29b. Signature and tile of certifier				29c. License	number		29d. Date sigr	ned (Month, L	Day, Year)
	N) VXX				P165	59		10-25	-04	
1	710		30. Name and address of person w	no completed cause of	death (Item 23a)	(Type, F	Print)					
				pracci mo	22 50	seff	Greene	Shut	Baltimo	ne mo	212	01
	Sta Registi		31. Date filed (Month, Day, Year)		trar's Signature	4	low	1	Baltimo			
			NOV 0 S	2004		~	ayour	1				

			For State Registrar	State of N	Maryland / Dep Ce	ertificate of	Health an f <i>Death</i>		giene 00 L	34721
	Dhysia		1. Decedent's Name (First, Middle,	Last)				2. Date of De		3. Time of Death
	Physic /Medi		Elsie Flore	ene Wheeler	~			October		08:30A. M
)	Exami		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Town,	or Location of D	Death	4c. County of D	Death
			Hammonds Lane No			Brookly	m Park		Anne Ari	
	Funeral			6. Sex 7. / 1 ☐ M 2 ☐ F	Age (In yrs. last birthda) 75 Yrs.	Months Days		Min. (Month, Da	th ay, Year) 9.	Birthplace (State or Foreign Country)
	Director		214.26.5319 Usual Residence of Decedent	X	75 Yrs.			July	31,1929 St	anton, VA
	land ow		10a. State 10b. County		10c. City, Town or I	ocation.				10d. Inside City Limits
	Mary 4 sh	ō	Md 7		Linthicu	ım				1 ☐ Yes ≱☐ No
	r 28a	Director	Md Anne A	Tunger	Difference	10f. Zip Code			10g. Citizen of Wha	t Country?
	within 72 hours after death with the Maryland ane. than "naturat", or items 23a or 28a-1 show to Mydical Examiner must be notified at	0	720 Wedeman Ave			21090				,
	ms 2	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U.S. 13		Hispanic Origin	? (Specify Yes or No Puerto Rican, etc.)	USA 14. Race - A	American Indian,
9	after or ite	F	1 Never Married 2 Marrie	Armed Force ed 1 Tyes 2 If Yes, Give	s? JNo			uerto Rican, etc.)		Vhite, etc.
03	ral', c	by	3 Widowed 4 Divorced	Year or Dates	S:	1 ☐ Yes 2 🛣 No	Specify:		Specify: W	hite
21215-0036	72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occu	ipation	f working	16b. Kind of Busine	ess/Industry
21	ithin ne.	du	Elementary/Secondary (0-12)	College (1-4o	or 5+)	e kind of work done DO NOT use retir	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	ygier ygier ygier ygier ygier	COI	7		F'ac	tory Wor				rporation
Maryland	1.2 should be filed within 72 hours after death with the Marylan h and Mental Hygiene. 7 is markad othar than "natural", or items 23a or 28a-1 show Iraumatic avant, the Modical Examiner must be notified at	Be	17. Father's Name (First, Middle, L	•				Name (First, Middle,	, Maiden Sumame)	
Z/a	s 1 and 2 should f Health and Men itam 27 is marka othar traumatic	2	Bernie Muthe	-				a Shell		
Jar	2 sh and is m	0	19a. Informant's Name/Relationsh	p (Type, Print)					er, City or Town, Stat	e, Zip Code)
_	and fealt m 2 har		Samuel Wheeler 20a. Method of Disposition	- Husband	/20 W	edeman A	ve. Lint	thicum, Mo		
0	Pages nent of Hunt: If its		1 X Burial 2 ☐ Cremation		20b. Place of Disp cemetery, cre	ematory or other pl	ace)	Date	20c. Location - City	or Town, State
tim	t. Pa tmen tant:	1.74	`4 □Donation 5 □ Other (Sp		Meadowrid	ge Mem.P	k. 11/	/3/2004	Elkridge,	Md 21075
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or ot once.		21. Signature of Funeral Service L	uma~	7	2. Name and Addi 250 Wash:	ington f	ry L. Kau Elkr	fman Fun' idge, Md	l Hm.at MMP In 21075
			23a. Part1. Enterthe disease, or of shock, or heart failure. List of	omplications that caus nly one cause on each	ed the death. Do not er line.	iter the mode of dy	ing, such as car	rdiac or respiratory a	rrest,	Approximate Interval Between
	Physician	10	Immediate Cause (Final disease or condition	HED	ATIC F	FAILUR	E			Onset and Death
	/Medical		resulting in death)		as a consequence of):					
и	Examiner		Sequentially list conditions.	b. C1	RRHOCIS	OF	THE	LIVER		
	р <u>;</u>	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	as a consequence of):					
	ecute and trans	cam	that initiated events resulting in death) Last	C						
8760,	cate be executed physician and the burial-transit	E E		Due to (or a	as a consequence of):					
87	cate l	dlcal		d						
9	The faw requires that the death certificate be executed tte has been signed by the attending physician and oage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:	23c. If yes, outcom	an of programmy					
Вох	atten atten for us	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnance	су		23d. Date of Month	delivery Day Year
o.	at the de by the tached	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		Other (specify)				
<u> </u>	that the ed by detac		Part II. Other significant condition	s contributing to death	but not resulting in the	inderlying cause d	ven in Part I	23e. Did to	phacco use contribute	e to the cause of death?
ds,	ires tha signed d be del	l by		,	-					Probably 4 Munknown
Records,	w requir been si should I	Completed						-		
360	e tav has je 2 s	Пфш						24a. Was	sv prior	autopsy findings available to completion of cause of
al								1 ☐ Yes	rmed? death 2 No 1 □ Y	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		0	h	Death (Check only o		-
of	Phys this aldii	2	1 ☐ Yes 2 No 27. Manner of Death	1 ∟ Inpa		III JU DON		-	dence 6 Other (S	pecify)
<u>_</u>	al or Attanding F i after death. I Diractor: After d in by the funer	Certification	1 Natural 5 Pending		njury 28b. Time of 28b Injury	Wo		28d. Describe n	now injury occurred	
Division	Attanding r death. actor: After by the fune	cat	2 ☐ Accident investiga 3 ☐ Suicide 6 ☐ Could no	ot be	nium. At home form of]Yes 2□No	294 Lanation (6	Step at a sell the sellen and	D / D
ì≥	or A after Dirac	rtif	4 Homicide determin	ed 286. Place of I	njury - At home, farm, si etc. <i>(Specify)</i>	reet, factory, office		City or Tow		Rural Route Number,
	Hospital or 14 hours afte Funaral Dir tely filled in I	Ö	29a. Certifier 1 Certifying	Physician: To the hou	at of the knowledge of the		les data and al			
	Hos 24 ho Fun stely f	edical	(Check only one)	xaminer: On the basis and manner:	st of my knowledge, dea of examination and/or in	n occurred at the to estigation, in my	ime, date and pl opinion, death o	lace, and due to the o occurred at the time, o	cause(s) and manner date and place, and c	as stated. lue to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Director completely filled in E	Mec	29b. Signature and title of certifier	and manner	J(Q(Q))	29c Licen	se number		29d. Date signed (Mo	onth Day Year)
	F 3 F 8		b &X			1	1775		11/1	
	(1.0)		20 Name and address of		death (the seas) (To a	D.:-0			1.1.1	- 7
	M		30. Name and address of person w	-MASENA	death (Item 23a) (Type	710 CH	MRCH	ST. BA	LTIMORE	m 21225
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 3 2004	Server 32. Regis	strar's Signature	ale				, MD 21225

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie [] [] Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EMMA C. WALLINGFORD 12304 11 0 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MANOR CARE RUXTON TOWSON BALTIMORE 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year 6/24/1917 9. Birthplace (State or Foreign **Funeral** Days Hours 1□ M 3€7F 334-16-7709 ILLINOIS Director Usual Residence of Decedent 10a State 10b, County 10c. City, Town or Location 10d. Inside City Limits ul Hygiene. . cither then "natural", or Items 23a or 28a-f show vent. Tre Medical Exercites traust be rutified at 1 Yes 2 No Completed by Funeral Director MD CARROLL HAMPSTEAD 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 18025 GUNPOWDER ROAD 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cent of Health and Mental Hyglene.
nt: if item 27 is marked other then "natural", or lier any or other treumatic event. Item Medical Examination 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH GRADE HOMEMAKER OWN HOME Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 JOHN STEPHENICH MARY BRATCHOVICH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHLEEN EARBECK DAUGHTER 18025 GUNPOWDER ROAD HAMPSTEAD, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State permit. Pages 1
Department of H
Importent; If ite
any injury or oti 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) METRO CREMATORY, INC. 11/3/2004 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician ZHEIMERIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial-t Box 68760. attending physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) P.0 detached he 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autocsy findings available prior to completion of cause of death? has autopsy performed 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 Z No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Jo this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Medical Certification; 5 Pending investigation Division Injury 1 Natural 2 Accident within 24 hours arrer coccur.

To the Funerel Director: Att 2 No 1 ☐ Yes 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 5905 PNEN MO

State Registrar Month, Day, Year)

NOV 0 3 2004

32. Registrar's Signature

			For State Registrar	State of N	laryland / [ment of H ficate of L		nd Men	tal Hygie Reg.		L	347	23
	Physic /Medi		1. Decedent's Name (First, Middle, La Evelyn Elaine Wa	•					2. 0	Date of Death Month Ctober	Day 2	Ŏ Ů 4	3. Time of D	Death
	Examir		4a. Facility Name (If not institution, given Upper Chesapeake		*	46	o. City, Town, or Be1				4c. County of	of Death		
	Funeral Director		214-22-6746		ge (In yrs. last birt 78		Under 1 Year onths Days	If Under 2 Hours	Min. (A	ate of Birth Month, Day, Ye	ear) 1926]	9. Birthp Cour Mary	lace (State or i try) land	Foreign
	show	20	Usual Residence of Decedent 10a. State 10b. County Md. Harfor	d	10c. City, Town	or Location						1	0d. Inside City	
	with the h a or 28a-1 Le rollli	Direct	10e. Street and Number 20 Boxhill South				10f. Zip Code	009		10g.	Citizen of W	hat Coun	trv?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene. Department of Health and Merital Hygiene. Inportant: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, The Medical Erand and Investigated any injury or other traumatic event, The Medical Erand and Investigated and Once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 25 If Yes, Give Year or Dates	t Ever in U.S. ?] No	If Ye	Decedent of His s, specify Cubar Yes 2 (2)No	spanic Origi n, Mexican, Specify:	n? (Specify) Puerto Ricar	Yes or No-	14. Race	- Americ , White,	an Indian,	
21215-0036	within 72 hor ane. than "natura ne Medical i	Completed by	15. Decedent's E (Specify only highest grants)/Secondary (0-12)	ducation ade completed) College (1-40)	5+)	(Give kind life. DO N	's Usual Occupa d of work done d NOT use retired)	urina most d	of working	16b	. Kind of Bus		lustry	
Maryland 2	uld be filed v Aental Hygie rked other tic event,	To Be Co	10 years 17. Father's Name (First, Middle, Last Clyde Stevens)	Sa	ales_			s Name <i>(Fir</i> s th McG	t, Middle, Maid OWan	reta den Sumame			
, Mary	alth and A		19a. Informant's Name/Relationship (Robyn Kalwa/daug				ddress (Street a						Code)	
Baltimore,	Pages 1 and the ment of He ant: If item ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specia		20b. Place of cemetery	Disposition y, cremator)	Date L/2/04	200	Location - C	ity or To		
Balt	permit. Departr Importa any inji		21. Signature of Funeral Service Licer	MA		$\perp 610$	ume and Address chimunel W. Mac	Phail	Road.	Bel Ai	Bel Ad	ir, I	Inc.	
	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	ine.	ot enter the	e mode of dying	, such as ca	ardiac or resp	piratory arrest,			Approximate Interval Betwee Onset and Dea	en ath
8760,	cate be executed by physician and the burial-transit and	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a consequence of a co	of):	nue P	omo	NACY	DISE	EACE			
O. Box 6	at the death certifi by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death	3 □Ecto 5 □ Oth	opic pregnancy ner (specify)				23d. Date Monti		y Day Yea	ır
ds, P	juires that n signed b	by	Part II. Other significant conditions of		out not resulting in		lying cause giver	n in Part I.	2	3e. Did tobacc		ute to the		
	sician: The law requires that the certificate has been signed by the irector, page 2 should be detache	Be Completed	ASCITES FOULCULAL LY 25. Was case referred to medical	mpitom A	Henr	it an	AILURE .	SIDS	1	4a. Was an autopsy performed?	24b. We	re autop or to com ath?	sy findings ava pletion of caus	ilable e of
Division of Vi	to the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, to	Control Cont												
DIV	e Hospital or At 24 hours after d e Funeral Direct letely filled in by		4 Homicide determined	28e. Place of In building, e	jury - At home, farr ic. (Specify) of my knowledge.	death occi	urred at the time	date and s	Diace, and du	ecation (Street ty or Town, Sta	ate)	05.00.010		
	To the Ho within 24 h To the Fur completely	Medical	one) 29b. Signature and title of certifier	and manner s	ated.		29c License	nion, death o	occurred at ti	ne time, date a	and place, and	due to t	he cause(s)	
	- s - ō		· Mh	/ (20		H55	922		NOV	EMBE	1	2004	-
N. C.	Star Registra	te	30. Name and address of person who a ANTHONY W. 31. Date filed (Month, Day, Year) NOV 0.3.2	SAWAIU 32. Registi	death (Item 23a) (T	Type, Print)	DO UPP	En Ch	ASS ARE	AICE	Drive	THE.	21014	1 MI

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Watson, Evelyn

			For State Registrar	State of M	Maryland / Dep <i>Ce</i>	artment rtificate	of H	ealth a	and M		giene Reg. No.	2004	34724
,	Physici /Medic		1. Decedent's Name (First, Middle, Last	1 WI	NGARD					2. Date of De. Month	Day	Year 2004	3. Time of Death
	Examir Funeral	ner	4a. Fecility Name (If not institution, give 913 DORKING ROAD 5. Social Security Number 6. Se		r) .ge (In yrs. last birthday,	GLE	N BU	Location o RNIE		8. Date of Birt	ANN	E ARUND	
	Director]M 212√xF	88 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da) 02/17/	y, Year) 1916		place (State or Foreign PA Od. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show appriatury or other traumatic event, the Medical Example Lunst be recitified at ance.	al Director	MD ANNE ARUN 10e. Street and Number 913 DORKING ROAD	IDEL	GLEN BURN						10g. Citiz	en of Whal Cour	1 ☐ Yes 21 No
-0036	hours after dea tural', or items	ed by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Deceden Amed Forces 1 Yes 2 X If Yes, Give Year or Dates	?]No :	1 Yes 2	No No	Specify:	in? (Spe , Puerto i	ecify Yes or No- Rican, etc.)	5	4. Race - Americ Black, White, Specify: WHI	etc. TE
Maryland 21215-0036	filed within 72 Hygiene. other than "natent, Ine Medic	e Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)		(Give life.	dent's Usual kind of work DO NOT use	k done di e retired) R	uring most		ng (First, Middle.	OWN	HOME	dustry
Marylan	d 2 should be in and Mental I is marked o traumatic eve	To Be	HAROLD (UNKNOWN) 19a. Informant's Name/Relationship (Ty		19b. Maili		(Street au	HALL I	E E.	McCOY	r, City or	Town, State, Zip	Code)
altimore,	. Pages 1 and Iment of Health tant: If Item 27 jury or other to		MRS. HALLIE JEAN GE 20a. Method of Disposition 1 Burial 2 1 Cremation 3 F 4 Donation 5 Other (Specify)	lemoval from State	20b. Place of Dispo cometery, cres CHESAPEAK	osition (Name matory or oth E CREN	e of ner place MATI	ON 1	1/02	2/2004	20c. Loca STEV	ation · City or To ENSVILL	E, MD
Ba	Departic Departic Imports any inju		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	anly	MO1415 1	SECO	ND A	VE. S	W GL	EN BURN	NIE,	AL HOME MD 2106	1 Approximate
8760,	Examine be executed /Medical Examine puties and the puties transit the puties transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due to (or as						A dis			Interval Between Cnset and Death
O. Box 6	death certific e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Prio 9 □ Unknown		2 Fetal death 3	Ectopic pred Other (spec				1 - 20	23	d. Date of delive Month	ry Day Year
ecords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions cor	stributing to death t	but not resulting in the u	nderlying cau	use giver	in Part I.			bacco use		e cause of death? ably 4 Unknown
Vital Rec	The ste h page	e Completed	25. Was case referred to medical							1	med? 2 Z No	prior to con death?	osy findings available inpletion of cause of 2 No
0	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	To B	examiner? 1 Yes 25 No 27. Manner of De ith 1 Phalural 5 Pending 2 Accident investigation	ospital: 1 □ Inpali 28a. Dale of Inj (Month, Da	ury 28b. Time of		Other c. Injury a Work?	4 □ Nurs	sing Hom	(Check only on ne 5 A eside 8d. Describe ho	ence 6[□Other (Specify)
Division	oital or Atteurs after de oral Directo	Certification:	3 Suicide 6 Could not be determined	building, e	jury - At home, farm, str lc. <i>(Specify)</i>					City or Towr	n, State)	Number or Rural	
	To the Hosy within 24 ho To the Fune completely fi	Medical	29a. Certifier (Check only one) 29b. Signature and title of or nifier	ician: To the best ner: On the basis of and manner st	of my knowledge, death of examination and/or in- tated.	estigation, ir	the time n my opir License i	nion, death number	occurre	d at the time, da	ate and pi	ace, and due to signed (Month, D	the cause(s) Pay, Year)
	:0		30. Name and address of person who co	mpleted caus	death (Item 23a) (Type, 45 OAN	. 1/	1	471	?) ex	o. Alex	1Re	mer,	2,0004
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registi	rar's Signature	south	4	VVY		, 0000	9	7/10	. , ,

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygienen 0 4 34725 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 705ZH Ronald E. Wishard, Sr. November 3. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Villa Nursing Home Catonsville Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 ☐ F Months Days Hours Yrs. Director 73 218-28-9423 Jun. 6, 1931 Pennsylvania Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Item 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event, If a Neulcal Exp. if et invet be profiled at tv Yes 2 □ No Director MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ¥ ∰ 2547 Marbourne Avenue 21230 United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2X Married Baltimore, Maryland 21215-0036 by 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be tiled within 7: th and Mental Hygiene. 7 Is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) 10 Maintenance Aluminum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charise Wishard Anna M. Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is n any injury or other treum 2002e. June E. Wishard Wife 2547 Marbourne Avenue, Baltimore, MD 21230 20b. Place of Disposition (Name of MeadOWTIGE 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 11-06-04 4 Donation 5 ☐ Other (Specify) Elkridge, MD Memorial Park 22. Name and Address of Faciliambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dilla to (or as a consequence of) Examine the attending physician and hed tor use as the burial-transit certificate be executed Ischem that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Vascoler DiJecse 1 ☐ Yes 2 ☐ No Probably 4 □Unknown Completed peen 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 E 140 funeral director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Dea 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred Hospitel or Attending atural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel within 24 hours a To the Funeral L 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 020103 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd 165 Catonsville, MD Ste 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 3 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34726 State Registramend ITEM #10f&19b PWER FH (89/tificpte) 9/10/20/20/20 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCTOBER 29, 2004 2004 WEINSTEIN 7:00 A M MARION /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner SILVER SPRING 15115 INTERLACHEN DRIVE #324 MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth SEP. 25, 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 79 NJ 148-14-7859 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 15115 INTERLACHEN DRIVE #324 20806 20906 USA items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural; or iter 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No WHITE Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) **PROPRIETOR** TRUSSEL'S DEPT. STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **EDWARD** TRUSSEL LILLIAN ELIN 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 15115 INTERLACHEN DR. #324 - SILVER SPRING, MD 20806 MOE WEINSTEIN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of I-Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 🖁 Removal from State 4 □ Donation 5 □ Other (Specify) OHEB SHALOM CEMETERY 10/31/2004 HILLSIDE, NJ 21. Signature of F 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or con tion Death Pnysician LUNG CANCER MONTHS resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 💢 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ hours after within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar NOV 0 3 2004

31. Date filed (Month, Day, Year)

32. Registrar's Signature

18111 PRINCE PHILIP DRIVE #322 - OLNEY, MD 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

death

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

Hospital or Attending Physician:

D42452

OCTOBER 29, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygierre 0 01

		1 - State Registrar		•	Ce	rtificate of	Death	Re	g. No.	14	34121	
Physici		1. Decedent's Name (First, Middle Esther Flora We						2. Date of Death		Year	3. Time of Death	
/Medic Examir	er	4a. Facility Name (If not institution Stella Maris Hos				4b. City, Town, o Balti	r Location of Death	OCTOBE?	4c. County	of Death	10.03	
Funeral Director		5. Social Security Number 200 12 7341	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs. i 78	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, June 10,		9. Birth Cou Penn	place (State or Foreig intry) ISYlvania	
ture!, or tiems 23a or 28e-f show	J.	Usual Residence of Decedent 10a. State 10b. County			y, Town or Lo						10d. Inside City Limits	
28e-f	Director	Maryland 10e. Street and Number		E	Baltimo	10f. Zip Code			000	10		
3a or		5 Polo Ct.				2122	1	16)g. Citizen of \ USA	wnat Cou	ntry :	
od other than "neture!", or Nems 23a or 28e-f show event, It's Mudical Exertirer must be notified at	Funeral	11. Marital Status 1 Never Married 2 Marr	Armed Fo		S. 13.		lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Rac	e - Ameri ck, White,	ican Indian, , etc.	
LENBER	þ	3 Widowed 4 K Divorced	If Yes, Giv Year or D	/e		1 ☐ Yes 2 ☒ No	Specify:		Specify	v: Whi	ite	
"nett	lete	15. Deceden (Specify only highes	t grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done	ation du <i>ring m</i> ost of worki d)	ng 1	6b. Kind of B	usiness/In	idustry	
other then vent, If & M.	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)		ction Wor			lectro	nics	Mfg.	
marked oth imatic event	To Be (17. Father's Name (First, Middle, Harry Adams	Last)				18. Mother's Name			ne)		
⊕ →		19a. Informant's Name/Relations Lorraine Jones		7)			and Number or Rura ltimore, I			State, Zip	Code)	
nt: If item ry or othe		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (S)		State	emetery, crei	sition (Name of matory or other place 1 Mem. Ga	ce)		oc. Location -	-		
Importent: If item 27 Is any injury or other tre once.		Holly Hill Mem. Gardens 11/1/2004 E 21. Signature (Funeral Service Licensee Bruzdzinski Funeral Home F 1407 Old Eastern Avenue Ess								P.A.		
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death							Approximate Interval Between	
sician edical	i	Immediate Cause (Final disease or condition resulting in death)	a	bo	tens	canh	5				Onset and Death	
miner			Due to (or as a consequ	uence of):							
sit	iner	Sequentially list conditions, if any, leading to initial solutions cause. Enter Underlying Cause (Disease or injury	Dua to (or as a consequ	ianca or):							
cian and vurial-tran	i Examine	that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):					-		
physics the t	Medicai		d									
ned by the attending physician and detached for use as the burial-transit	hysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1☐Live b	come of pregna irth 2 Petal ant at time of de own	death 3	Ectopic pregnancy Other (specify)			23d. Dat Mo	e of delive	ery Day Year	
90 PB	by P	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the u	nderlying cause give	en in Part I.	23e. Did toba	_	ribute to th	he cause of death?	
has been si ge 2 should	ompieted							24a. Was an autopsy	24b. V	Vere auto	psy findings available mpletion of cause of	
pag	O							perform	ed? ∃No 1	ieath?	2□ No	
is certificate director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	npatient 2 1	ER/Outpatien	at 3 DOA Oth	26. Place of Death er: 4 \(\sum \) Nursing Hon		-	or (Specif	w hoen -	
r: After this e funeral di	atlon; T	27. Manner of Death 1 Natural 5 Pendin 2 Accident Investig	28a. Date of		28b. Time of Injury	28c. Injun Worl	at 2	8d. Describe hov			oriospire	
ol Directo	Certification;	3 Suicide 6 Could r 4 Homicide determ	ned 286 Place	of Injury - At hong, etc. (Specify	me, farm, str	eet, factory, office	2	8f. Location (Stre City or Town,	et and Numb State)	er or Rura	I Route Number,	
To the Funerel Director: After th completely filled in by the funeral	edical C	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the ba and mann	asis of examinat	wledge, death ion and/or inv	n occurred at the time vestigation, in my of	ne, date and place, a pinion, death occurre	nd due to the cau	ise(s) and ma e and place, a	nner as st	ated. the cause(s)	
To the Complet	Me	29b. Signature and title of certifier	~~~			29c. License		29	d. Date signed	Month,	Day, Year)	
3			serg 381	5T PO	UI PI	Print) Baltin	ière ind	2/28				
Sta	te	31. Date filed (Month, Day, Year)	32. R	egistrar's Signat	ure							

DHMH 17 Rev 1/2001

Registrar

NOV 03 2004

State of Maryland / Department of Health and Mental Hygier 34728 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Clayton Dexter Zucchi November 2004 4:50 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1642 Saint Paul Street Hampsteau

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (Jointon Country)

April 2, 1928 | Massachusetts Hampstead 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 11X M 2 □ F 030-16-7447 76 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Carrol1 Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1642 Saint Paul Street 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1950 1 Yes 28 No Specify Specify: White Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene.
7 Is marked other then "I Elementary/Secondary (0-12) College (1-4or 5+) Electrician Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles John Zucchi Ina Mae Babbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Ian any injury or other traun once. 1642 St. Paul Street; Hampstead, Maryland 21074 Clyde Allen Son-in-Law Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem. Garden 11/4/04 Marriottsville, MD 21. Signature of Funeral Service Licensee Sterling Ashton Schwab Funeral Home, 736 Edmondson Avenue; Catonsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner death certificate be executed transit and Due to (or as a consequence of): the burial-Box 68760, Fbullann the attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 5 Other (specify) P.O. I certificate has been signed by the a rector, page 2 should be detached in Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 1 Nos 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 10 110 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes Other: 4 \(\to \) Nursing Home \(5 \) Desidence \(6 \) Other (Specify) ဥ 2 N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Đ 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After the funeral by the fur 5 Pendina investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Neertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign: 0054218 Malany dire, Westmarty MD 21150) of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address umay Keiner 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

32 Registrar's Signature

0 3 2004

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** Zink James 2004 Nov 10:30AM /Medical 4b. City. Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner 803 High View Place Burnie Anne Arundel If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthdey) 8. Date of Birth (Month, Day, Year) Birthplece (Stete or Foreign Country) **Funeral** Deys Months 12 M 2□ F Yrs Director Feb. 12, 1942 Maryland 216-42-0444 Usuel Residence of Decede with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after death with the Manylan nent of Health end Mental Hygiene.
ant: If Item 27 is marked other than "naturel; or items 23s or 28s-f show ury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 803 High View Place 21060 U.S.A. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: ð 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 N/A Fleck Machine Co Machinist 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Carl Zink Thelma Wiseman 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Genevieve K. Zink (Wife) 803 High View Place Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. 11/04/04 Glen Burnie. 22. Name end Address of Fecility
McCully-Polyniak Funeral Home, P.A. 21. Signature of Funeral Service Licenses 3204 Mountain Road Pasadena, Md. 21122 Ulun 23a. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardiac or respiretory errest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical cleans Examiner Due to (or as a consequence of) Physician/Medical Examin ettending physician and for use es the bunal-transit The lew requires that the daath certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Lest Due to (or as e consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 36 Probably 4□ Unknown 1 ☐ Yes 2 ☐ No þ certificata has been si lirector, paga 2 should l 24a. Wes en autopsy performed? 24b. Were eutopsy findings Completed available prior to completion of cause of deeth? 1 Tyes 1 Tes or Attending Physician: funaral director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) After this 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Vaturel 5 Pending Injun 1 Tes 2 🗆 No within 24 hours aftar death.

To the Funeral Director: A completely filled in by the fu investigation 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as steted.

| Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred et the time, date and place, end due to the cause(s) and manner steted. 29a. Certifier (Check only one) Medical 29b. Signature end title of certifi 29c. License number 29d. Date signed (Month, Dey, Yeer) 30. Name end 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar NOV 0 3 2004

DHMH 16 Rev 6/95

ORIGINAL

LIN	N ALFR	ce.		State of Maryland	/ Depa	ırtment		and M	ental Hyg	ene .		34730	
	Physic /Medi		1. Decedent's Name (First, Middle, Last) Edwin N. Alfree						2. Date of Death Month OCTOBER	Dav	Year 2004	3. Time of Death 3:03 P M	
}	Examir		4a. Facility Name (If not institution, give str 70 ADAMS DR	et and number)			wn, or Location MPTON	of Death		4c. County QUEEN	of Death		
	Funeral Director		5. Social Security Number 6. Sex $222-60-8552$ $1 \times 10^{-1} \times 10^{-1}$	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Months E	Year If Under Days Hours	Min.	8. Date of Birth (Month, Day, Sept. 30,	1979	9. Birthp Coun DE	lace (State or Foreign try)	
	e Maryland ta-f show tiffed at	ctor	10a. State 10b. County MD, Queen Anne		Town or Loon	cation					1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	th with the 23a or 28	al Dire	10e. Street and Number P.O. Box 44 70 Ada	ms Drive		10f. Zip Co 216	ode 528		10	g. Citizen of V USA	What Coun	try?	
980	ours after dea rel', or Items Examinarm	by Funeral Director	11. Marital Status 12 1 Xever Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZaNo If Yes, Give Year or Dates:	lf	Vas Deceden Yes, specify	t of Hispanic Or Cuban, Mexica No Specify.		cify Yes or No- Rican, etc.)	Blac	e - Americ ck, White, Whit	etc.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene, item 27 le marked other then "naturel", or items 23a or 28a-f show other treumatic event, the Medical Exprend of the recomplished at	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 11	College (1-4or 5+)	16a. Deced (Give I life. L		Occupation done during mos retired)	st of workir	ng 1	6b. Kind of B		,	
land	ild be file lental Hyg ked othe	To Be C	17. Father's Name (First, Middle, Last) Edwin Wilson Alfree	, Jr.					(First, Middle, M				
Maryland	and 2 should be feath and Mental Heath and Mental Heath and 27 le marked of the treumatic eve	-	19a. Informant's Name/Relationship (Type Mary Jane Collison)	Print)			treet and Numb	er or Rura	Route Number,				
Baltimore,	6 = 5		20a. Method of Disposition 1 □X3urial 2 □ Cremation 3 □ Ren 4 □ Donation 5 □ Other (Specify)	20b. Plac	ce of Dispos	sition (Name	of r place)	D		0c. Location -	City or To	wn, State	
Balti	permit. Pa Departmen Importent: eny injury once.		21. Signature of Funeral Service Licensee		22. Name and Address of Facility Fellows, Helfenbein & Nev 130 Speer Road, Chesters that caused the death. Do not enter the mode of dying, such as cardiac or respirato						ewnam, P.A.		
	Physician /Medical Examiner	ıer	23a. Jart1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	ce of):		f dying, such as		respiratory arre	st,		Approximate Interval Between Onset and Death	
8760,	ate be executed hysician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d	Due to (or as a conseque	nce of):								
.O. Box 68	The law requires that the death certificat tie has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnand 1 Live birth 2 Fetal de 4 Pregnant at time of deal 9 Unknown	eath 3 🗆	Ectopic pregr Other (specil				23d. Dat Mor	e of deliver	y Day Year	
ords, P	w requires that been signed b should be deta	by	Part II. Other significant conditions contri	outing to death but not resulti	ng in the un	derlying caus	e given in Part I					cause of death?	
Vital Records,		e Completed	25. Was case referred to medical						24a. Was an autopsy perform	ed? c	Vere autoporior to com leath?	sy findings available inpletion of cause of	
Division of Vit	tending Phye Jeath. tor: After this the funeral di	ertification: To Be	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 2 Accident investigation	28a. Date of Injury (Month, Day Year)	1	28c. 2 H/U et, factory, of	Cther: 4 Nu Injury at Work? 1 Yes 2	rsing Hom	(Check only one 16 5 Residen 18 Describe how 18 Location (Stree City or Town,	ce 6XOpther injury occurr	uy	Pouto Number	
Ω	Hospitel 4 hours a Funerel ely filled	edical Ce	29a. Certifier (Check only one) 1 Certifying Physici 2 Medicel Exeminer	en: To the best of my knowle On the basis of examination and manner stated.	edge, death	occurred at the	ne time, date an my opinion, dea	d place, ar	vinneton	Mar	7/Am	ated.	
)	To the within 2 To the complet	Med	29b. Signature and title of certifier	- Stated			cense number			d. Date signed		*	
	Sta Registr		30. Name and address of person who compared the UNCAE M (M) (1) 31. Date filed (Month, Day Year) 2 0 1				1 Penn :	Stree	et, Balt	imore,	Mary.	land 21201	
DH	MH 17 Rev 1/2	8 1			DICINIA	5000		-			75170		

State of Maryland / Department of Health and Mental Hygiene Reg. No. 0 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Christine G. Adams 10:45AM CETOBELL 17, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Doctor's Community Hospital Lanham Prince George's 8. Date of Birth (Month, Day, Year) Aug 15, 19 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2ĂF Months Days Hours Min. 220-60-6734 Director 52 Cheverly, MD Usual Residence of Decedent with the Maryland itam 27 is markad other than "natural", or Itams 23a or 28a-f show other traumatic event. the Mudical Examinar must be motified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's Maryland 1⊠Yes 2 No Lanham Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9885 Greenbelt Road 20706 death 1 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. □Yes 2 No Yes, Give 1 Never Married 2 Married White 1 ☐ Yes 2 ☑ No Specify: \$ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other then "any injury or other traumatic event, the Max Elementary/Secondary (0-12) College (1-4or 5+) Accounts Receivable 12 Telecommunications 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Henry M. Adams Margaret K. Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stacie A. Kelly -Sister 11807 Chapel Road, Clifton, VA altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1₺ Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 10/22/04 Silver Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Fervice Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 1201373 4739 Baltimore Ave., Hyattsville, MD 20781 Month 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 51-110 200 /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physicien Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. detached 1 Yes 2 King 9□ Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2 No 1 🗌 Yes or Attending Physician: tuneral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check onl. one To Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1. Inpatient 2 ☐ ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Matural 5 Pending hours after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) tilled in by 4 Homicide determined within 24 hours a 12 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 46093 VO MO 30, Name and address of person mpleted cause of death (Item 23a) (Type, Print) 7305 Hanover OKWY Countrelt, MD 20770 moslagi 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 0 2004 Registrar

Sample S		1. Decedent's N									2. Date of Deat Month	Day	Year	3. Time of D
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S. Social Security Numbers 8. Days 10 ml	iner					nter				or Death				
Total County Tota	1			6. Sex	7. Age (In		day) If Unde	er 1 Year	If Under		8. Date of Birth		951 9. Birti	hplace (State or I
MD Prince George's Landover 102. Stream and Number of Prince George 109. Citizen and Number of Prince		Usual Residence	e of Decedent		34		S	Days	riogis				Wasi	nington,
A Donation S Other (Specify) Mount Offivet 10/21/04 Washington, DC	tor													10d. Inside City
*4 Donation 5 Other (Specify) Mount Office 1.0721/04 Washington, DC 22. Name and Address of Facility J. B. Jenkins Funeral Hom 7474 Landover Road Landover, Maryland 2078 Specific Final disease or condition remarks the final disease or condition remarks the first only one cause on each line. *Brain Tumor Due to (or as a consequence of): Glioblastoma Muitiforme Due to (or as a consequence	Direc	10e. Street and		Terrace							1	-		untry?
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A Donation S Other (Specify) Mount Offivet 10/21/04 Washington, DC		20a. Method of	Disposition		20	h Place of D	ienocition (N	ama of	1		-			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximated cause (Final disease or conditions. if any, leading to immediate Cause (Disease or injury trainitated event).										10/21	/04 1	lash	ington	,DC
23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximated cause (Final death) Construction of the cause of the cause (Disease or or injury tarrest)	i i	21. Signature o	of Funeral Service	Licensee	7		22. Name a	and Addres	ss of Facilit	y J.	B. Jenk	ins	Funera:	1 Home
shock, or heart failure. List only one cause on each line. Interval in mediate Cause (Final disease or condition resulting in death) Brain Tumor Due to (or as a consequence of): Glioblastoma Muitiforme Due to (or as a consequence of): Glioblastoma Muitiforme Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (Si .	1 / _	6	3	<u> </u>		7474 I	andov	ver R	oad 1	Landover	, Ma	ryland	20785
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) that initiated events resulting in death) Last Due to (or as a consequence of):		Immediate Cau	use (Final											Interval Betwe
24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 24a. Was an autopsy performed? 1 Yes 2 No 3 Probably 25. Was case referred to medical easth? 1 Yes 2 No 3 Probably 26. Place of Death (Check only one) 27. Was case referred to medical easth? 28. Place of Injury at work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred	r	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Clioblastoma Muitiforme Due to (or as a consequence of): C. Due to (or as a consequence of):												Onset and De
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D 51520 10-18-04	edical Certification: To Be Completed by Physician/Medical Examiner	Sequentially lis if any, leading cause. Enter U Cause (Disease that initiated ever sulting in deal of the cause). If FEMALE: 23b. Was dece in the pas 1	ath) It conditions, to immediate inderlying e or injury ents with Last It 12 months? 2 No own Ignificant conditions of the condition of the	Du G1 b. G1 c. Du d. 23c. If yea 1	ie to (or as a cor ie to (or as	nsequence of) oma Mu nsequence of) nsequence of) egnancy Fetal death of death of death t resulting in the 2 □ ER/Outpa 2 □ ER/Outpa 1 28b. Time Inju At home, farm pecify)	itifor : : :: :: ::: ::::::::::::::::::::::	pregnancy specify) cause give cause give 28c. Injun Word 1 1 200 ory, office d at the tim nn, in my office 9c. License	26. Place er: 4X Nu y at K? Yes 2 me, date an pinion, dea e number	No 2	1 Ye 24a. Was ar autops perform 1 Yes 2 (Check only one 5 Reside 28d. Describe ho 28f. Location (Str. City or Town and due to the caed at the time, de	ed? The control of t	Month a contribute to No 3 Pro 24b. Were au prior to c death? 1 Yes Other (Spec occurred	the cause of deal obably 4 JUnitopsy findings avompletion of cau 2 No No North Number stated. To the cause(s) of Day, Year)

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2 0 0 1 34733 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year Edna Mae Archer October 16, 5:30P 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George Hospital Cheverly Prince George If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 ☐ M 2 🖸 F 93 Yrs. 072-20-4832 Director April 15, 1911 Georgia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☑ Yes 2 ☐ No Directo Maryland Prince George Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 21s marked other than "---' any injury or other traumer." 7205 Katic Laurel Court 20744 Items 23a United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify: 3 ₱ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 6th Domestic Worker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lucious Brown ဥ Anna Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Archer/Daughter 7205 Katie Laurel Ct.; Ft. Washington, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Roadside Cemetery Oct. 23, 2004 Hertford, NC. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Pope Funeral Homes; 21. Signature of Funeral Service Licensee 5538 Marlboro Pike Forestville, MD. 20747 23a. Part1. Enter the disease, or compleations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Acute Anterior Lateral MI hours resulting in death) /Medical Due to (or as a consequence of): Examiner Athrosclerotic Cerebral Disease year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ probable ischemic bowel ed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Complet 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1□ Yes 2 No Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA this After this funeral d 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Diractor: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) a Funaral Diract filled in by 4 Homicide 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 24 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D32261 October 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael J. Feldman, MD. 9500 Annapolis Rd; Lanham, MD. 31. Date filed (Month, Day, Year) Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

OCT 1 9 2004

Amended Items 1 & 2 per Physician 10/28/2004 Carroll County, wj1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 👢 34734 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 2004 **Physician** 0100 Vasiliki Amprazis Bessie H. Amprazis AKA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ctr Westminster Nursing and Convalescent Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign December 10 1908 Greece 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 95 213-50-4162 Greece Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Carroll Westminster Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21157 22 Goni Terrace USA Funerai Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2**XXX**0 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed by 3XXVidowed 4 □ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry during most of working than . Elementary/Secondary (0-12) College (1-4or 5+) Harry's Lunch permit. Pages 1 and 2 should be filled wil Department of Health and Mental Hygiens Important: If Item 27 is marked othar that any injury or other treumatic event, ILE QDG. Owner/Co-founder 5 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Akaterine Soulimetse Christos Tsaknis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD Zoe Sirinakis/daughter 22 Goni Terrace 20b. Place of Disposition (Name of cemetery, crematory or other place)
Westminster Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 10/21/2004 Westminster, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Livins Prints Furieral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter of disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): reelic /Medical Examiner Sequentially ist conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit the attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Year 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certification; To Be Completed by 2 200 3 Probably 4 Unknown 1 Tyes peeu 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate 1 Yes 2 🖳 No : After this certifica e funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 Yes 2 XÑo 4 Sursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours after the Funerel Dire Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier mpletely (Check only one) the 29c. License number 29b. Signature and title To Wish 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature Mr. Kus 31. Date filed (Month, Day, Year) 1 9 2004 Registrar It spelle

			1- State of Maryland / De State of Maryland / De State	epartment of Health and No		ene2004	34735
100	₩ .73	-3	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
	Physici /Medic		Mary Johnson Addison		Month	Day Year R 14 2004	2:40 PM
)	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
			Johns Hopkins Bayview Care Cont	er Baltimor	2		
ķ.	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	day) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	8. Date of Birth (Month, Day,)	rear) Couit	place (State or Foreign
W	Director		006-28-0336 1□M 2\XF 79 Yr	S.	Feb. 14,		Ĵersey
and	š		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of the County 10c. City, Cit	or Location		1	10d. Inside City Limits
Aaryl	of a	٥					1 □ Yes 2 🛣 No
the	288-	Director	Maryland Prince George's Bowie	10f. Zip Code	100	g. Citizen of What Cour	ntov?
with	la or		6406 South Homestake Drive	20720	100		y:
leath	13 2.	Funerai			pecify Yes or No-	U.S.A.	can Indian.
fler	r Ho	F	1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No	 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 	Rican, etc.)	Black, White,	
UTS a	o, ja	by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2X No · Specify:		Specity: Wh	ite
d 21215-0036 filed within 72 hours after death with the Maryland	ratur Ical	Completed	15. Decedent's Education 16a. C	ecedent's Usual Occupation	16	Sb. Kind of Business/In	dustry
Pin V	en "r	ρie	(Specify only highest grade completed) ((Specify only highest grade completed) ((Specify only highest grade completed)	Give kind of work done during most of work fe. DO NOT use retired)	King		
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ב <u>ב</u>	ital hygiene. d other than "natural", or items 23a or 28a-f show event, it a Medical Examinetr mai be mulified at	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	aiden Sumame)	
arylan should be	nd Mental Hygi marked other matic event,	ပ္	Charles Haldane Johnson	Sophie	Sanders		
~ ~	2 to 20		19a, Informant's Name/Relationship (Type, Print) 19b. N	Mailing Address (Street and Number or Ru. Box 309 - Upper Mar	ral Route Number, (City or Town, State, Zip	Code)
	im 27 har tr			Box 309, Upper Mar 6 South Homestake I			
Ore	r ite		20a. Method of Disposition 1 ☐ Buriaſ 2 🎇 Cremation 3 ☐ Removal from State	isposition (Name of crematory or other place)		Dc. Location - City or To	
Pages	ment lant: I jury o		'4 □Donation 5 □Other (Specify) Metropo			lexandria,	
Baltimore, permit. Pages 1 ar	Department Important: I any injury o once.		21. Sign ture of Funeral Service Licens	22. Name and Address of Facility Gas 4739 Baltimore Ave			
			23a/ Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.				Approximate Interval Between
Ph	ysician		Immediate Cause (Final				Onset and Death
	Medical		disease or condition resulting in death) Due to (or as a consequence of)	:		-	
Ex	aminer		Sequentially list conditions b. COTONARY OF	ten disease			
T.	A	ner	if any, leading to immediate Due to (or as a consequence of)				
cutec	nd ransi	Examiner	cause. Enter Underlying Causes Creedes of injury that initiated events c.	e replacement			
Ö,	sician and burial-transit		resulting in death) Last Due to (or as a consequence of)				
58760, ficate be executed	<u>≽</u> ₽	edical	a Sick sinus	syndrome			
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Geath death	d for	icia	in the past 12 months? 1 Ves VNo 4 Pregnant at time of death	3 ☐Ectopic pregnancy 5 ☐ Other (specify)			Day Year
) <u>§</u>	by the	hys	9 □ Unknown 9 □ Unknown				
ecords, P.O law requires that the	igned t	ру Р	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did toba	cco use contribute to th	ne cause of death?
ğ ell	gis ue uld blu		hypertension, cerebral vas	cular accident	1 ☐ Yes	2 No 3□ Prob	ably 4 Unknown
0 º	s been s	Siet	(1		24a. Was an	24b. Were auto	psy findings available
The It	page 2	Completed			autopsy	prior to cor death?	mpletion of cause of
	certificate rector, pag	Ö	25. Was case referred to medical	26 Place of Deat	1 ☐ Yes 2 ☐ h (Check only one)	No 1 □ Yes	2 No
		0 0	examiner? 1 ☐ Yes 2 No Hospital: 1 ☑ Inpatient 2 ☐ EP/Outp.	Othor		ce 6 Other (Specify	d
	<u>च</u> ≘	1	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of 28c. Injury at	28d. Describe how		"
VISION	ath. r: After e funer	atio	tatural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation	M 1 ☐ Yes 2 ☐ No			
DIVISION I or Attending	atter death. I Director: A d m by the fu	Hica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office		et and Number or Rura	l Route Number,
اَمْ كَ	od in	Certification;	4 Homicide Setermines building, etc. (Specify)		City or Town, S	State)	
DI To the Hospital or	within 24 hours after de To the Funeral Direct completely filled in by t	edical	29a. Certifier (Cnecx only one) 1 ertifying Physician: To the best of my knowledge, compared to the basis of examination and/connect stated.	eath occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the caus	se(s) and manner as st and place, and due to	ated. the cause(s)
the	within 2 To the comple	Med	one) and manner stated. 29b. Signature and title of certifier	29c. License number		. Date signed (Month, I	
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0	(1)) 	2010		Ole D	,	-cay
K	(12)		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print) 5205	e lecon I	Cay vias c	700
	Sta	te	31. Date filed (Month, Day, Year) 2. Registrar's Signature-	Pallir	core 1	1 4 22	7
83 6	Registr	_	OCT 1 9 2004 Klein & A	rede			

ORIGINAL

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Maryla		artment of H rtificate of			iene 004	34737		
	Physici		1. Decedent's Name (First, Middle, Last Lawrence Lar	•	rry			2. Date of Dear Month Oct. 1	th Day Yea 5, 2004	3. Time of Death 8:00 a ^M		
	/Medic Examin Funeral Director		Aa. Facility Name (If not institution, give North Arundel F. Social Security Number 6. Se	street and number) Iospital	rs. last birthday)	4b. City, Town, o Glen I If Under 1 Year Months Days		8. Date of Birth	4c. County of Do	eath		
	ס	or	577-04-6449 Usual Residence of Decedent 10a. State MD Anne Aru		City, Town or La	ocation Odento) n	11-16-	1963 wa	10d. Inside City Limits 1 ☐Yes 2 ☐ No		
	th with the P 23a or 28a-	Funeral Director	10e. Street and Number 711 Linden Grov			10f. Zip Code	21113	1	0g. Citizen of What	Country?		
936	72 hours after death with the Maryland natural", or ttems 23a or 28a-1 show Itsel Evantinat Let sydiffed at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	Black, W	merican Indian, thite, etc. Black		
21215-0036	⊆ ⊴	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use retired	during most of work		16b. Kind of Busine			
Maryland 2	ould be fited with Mental Hygiene. arked other than atic event, tra P	To Be Co	17. Father's Name (First, Middle, Last) Lawrence Edwar	d Berry					Maiden Sumame)	· · - · · ·		
	1 and 2 shoul Health and Mi tem 27 is mari		19a. Informant's Name/Relationship (7) Sandi Berry/ Wil 20a. Method of Disposition	fe		Linden	Grove P	lace, (City or Town, State $0 denton$, $20c$. Location - City	MD 21113		
altimore,	t. Page rtment o rtant: If rjury or		1 Burial 2 Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerar Service L@	Removal from State L	incoln	matory`or other plac Memoria	10-2	1-04	Suitland Funeral	, MD		
Ba	permi Depa Impo any ir any ir		23a. Part1. Enter the disease, or compshock, or heart failure. List only of	lications that caused the d	1 7 eath. Do not ent	22 Nort	h Capit ng, such as cardiac	ol St. or respiratory arro	NW Wash			
	Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	aDue to (or as a con:			ve Sleep			minutes Hears		
68760,	ificate be executed g physician and as the burial-transit	cai Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a con:	sequence of j.	Oberit				years		
P.O. Box 68	death cert e attendin ed for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	/		23d. Date of a	delivery Day Year		
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 2 Unknown		
Vital Records,	The ate h page	Completed						24a. Was a autops perform	y prior			
of	iing Physician: Th n. After this certificate funeral director, pag	on; To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year	ER/Outpatier 28b. Time of Injury		er: 4 Nursing Ho		ence 6 Other (S	pecify)		
Division	or Attenction death	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.			Yes 2 □No	28f. Location (St City or Town		Rural Route Number,		
	To the Hospital within 24 hours a To the Funeral Completely filled in	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	To With con	2		ul Beck, M	(D)	1) 46052		10/15			
2	(10)		30. Name and address of person who of Sirolad Bech, 31. Date filed (Month, Day, Year)				ry ann	arolis, t	70			
	Sta Regist		OCT 1 9 2004	2. Registrar's Si	K April	W						

State of Maryland / Department of Health and Mental Hygiene Reg. 80.004 1 - For Stata Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** OCTOBER Joseph 13 2004 Alonzo /Medical 4a. Facility Name If not institution, give street and number) 46. City, Town, or Location of Death 4c. County of Death **Examiner** dins Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign Sex 14 M 2□ F **Funeral** Days Months Hours Country)
Illinois 13, Director 468-50-5611 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other treumatic event, If a Marical Expolication of the nullified at once. X□Yes 2□No Stafford Stafford Directo Virginia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2000 Wave Drive 22554 United States Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.3— Armed Forces? 1983— 1 ¥Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Coltege (1-4or 5+) Elementary/Secondary (0-12) Physician Medica1 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Joseph Alonzo Berry, Sr. Ernestine Siggers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2000 Wave Drive, Stafford, Virginia 22554 Miriam Berry (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ABurial 2 □ Cremation 3 □ Removal from State 10/19/04 Rock Creek Cemetery 4 □ Donation 5 □ Other (Specify) Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityMcGuire Funeral Service 7400 Georgia Ave. N.W., Wash. D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death mmediate Cause (Final Pulmonary Hypertension Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Veno-occlosive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ò 5 Other (specify) 4☐Pregnant at time of death P.O. 1 sate has been signed by the a page 2 should be detached in 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2□ No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 Yes this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 2 Accident 5 Pending after death. investigation 1 Yes 2 No To the hosp...
within 24 hours after dean
To the Funerel Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 October 17, 2004 mo +1 10 Baltimore 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1830 East Monument Street maryland 21287 Scott Stephens, MD 5th Floor 1830 Building 31. Date filed (Month, Day, Year) 32. Registrar's Signature State merca Registrar 19 2004 OCT

		1 - For State Registrar	State of I	Marylar		artment of tificate o		nd Mei		ene g. No.	004	347	39	
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ylarid buld be fill Mental Hy arked oth attc evant	ToB	John Bentz					Anna	Trot	tner					
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Ball	permit. Page Department Importent: If any injury o	22. Name and Address of Facility Stauffer Fur 8 E. Ridgeville Blvd. Mt. A											
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Box	leath certifice attending ph I for use as th	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, 1⊟Liv	outcome of pregna	ancy al death 3 (⊒Ectopic pregnanc	٧			23d. Dat	e of deliv	ery Day Year
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State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) OCTOBER 18, Day 2004 **Physician** HENRY JOSEPH BARBOUR 6:10 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES LAPLATA CENTER, GENESIS ELDER CARE LA PLATA If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ₹ M 2 □ F Yrs. 219-20-7884 83 DECEMBER 1. 1920 | MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County or Items 23e or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2x No CHARLES MD INDIAN HEAD Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5345 MASON SPRINGS ROAD 20640 UNITED STATES Funeral permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural pages. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be WILLIE BARBOUR NELLIE THOMPSON BARBOUR ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MICHAEL BARBOUR/SON 5345 MASON SPRINGS ROAD, INDIAN HEAD, MD 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) RESURRECTION CEMETERY OCT 23, 2004 CLINION, MARYLAND 21. Sign ture / Funeral Service (10 of e THORNTON FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 2117 ∳nysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2. No Division of Vital 26. Place of Death (Check only one, 25. Was case referred to medical examiner? Certification: To Be Hospital: 1 Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 📆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. plame and address of person who completed cause of death (Item 23a) (Type, Print) FYZEV? C 31. Date filed (Month, Day, Year) 32. Re State OCT 2 0 2004 Registrar

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23.8 Part. Enabled deases, or condition to the cause of each line. Physician / Medical Examiner Physician / Medical Examiner The property of the cause of each line. Due to (or as a consequence of): Due to	Page ant: If ary or a	1 □ Burial 2 ★ Cremation 3 □ Hemoval from State '4 □ Donation 5 □ Other (Specify) Carro	11 Cremation, Inc 10/20	
Physician Medical Examiner Physician Medical Examiner	Ball permil Depar Impor any ir	Mark Relieur	412 Washington Road 1	Westminster, MD 21157
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	al Recc			autopsy performed? performed? performed? death?
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30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	Divis	4 Homicide 4 Homicide 28e. Place of Injury - At home, 1 building, etc. (Specify)		
30 Name and address of person who completed cause of death (Item 23a) (Type, Print)	ne Hospite n 24 hours ne Funere bletely fille		e, death occurred at the time, date and place, and du nd/or investigation, in my opinion, death occurred at t	le to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	To the within To the company of the the company of the the company of the the the the the the the the the the			29d. Date signed (Month, Day, Year)
Gerde X ACCTAL DEC 12 200 - 1 COLOR CHILD	1004	30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)	(D. D., M. 114 and 2
State Registrar George J. HUS To L. DES M.D. 20 Crossroads Dr St 10 Owings Mills, MD 2111 State Registrar OCT 18 2004 Slegen & Joseph		31. Date filed/(Month, Day, Year) 32. Registrar's Signature	M. A. N.	0 0 0 mings 11113, 11110 21117

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 34743 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 2004 October 17, 7:45 a Francis Bergen Joseph /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Calvert Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** Months 1 MM 2□ F Director 578-07-2745 July 3,1917 Washington, DC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28e-1 show the Medical Examiner roust by notified at 1 Yes 2 No Director North Beach Calvert MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 9110 Erie Avenue 20714 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene Important: If item 27 is marked other then "neturel", or items 23e any injury or other treumetic event, the Medical Examinary ADRE. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 9 book binder Government printing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Edward Francis Bergen Magdeline Dolan 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 734, Chesapeake Beach, MD 20732 Rosalie B. Russell, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 10/20/2004 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign to of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOBE BILATERAL LOWER Pnysician /Medical Due to (or as a consequence of): wee K **Examiner** PNEUMO Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4□Pregnant at time of death P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes o the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury at Work? 1 Aatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deatlunered 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours at To the Funerel D completely filled is 29a. Certifier 1 🗙 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Prince Trederick, MD 20678 116. Spital 110 Munshi 31. Date filed (Month, Day Year) 32. Registres Signature State 18 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1- State Amend Items 28a-f per ME G837 11 101 /04 11 12-3-04 tasneg. No. 34744 2. Date of Death 1. Decedent's Name /First_Middle_Last! 3. Time of Death Month **Physician** 1744 OCTOBER 10 2004 Monica Dawn Bowling /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12146 CATALINA DRIVE LUSBY CALVERT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | May 1.00 th. 0.00 year 9 69 5. Social Security Number 212-11-4641 7. Age (In yrs. last birthday) 35 Yrs. 9. Birthplace (State or Foreign **Funeral** Months Virginia Director Usual Residence of Decedent 10a State 10b, County 10c, City, Town or Location 10d. Inside City Limits ral, or Items 23a or 28e-f shore Extended at the restlined at MD Calvert Director Lusby 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12146 Catalina Drive 20657 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐Yes 2X No Yes, Give 1 ☐ Yes 2 No Specify: white Specify: þ 3 Widowed 4 Divorced Year or Dates: ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complet Elementary/Secondary (0-12) College (1-4or 5+) Receptionist Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Clay Chambers Sandra Compton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Conoy Place, Faulkner, MD Frederick Bowling/Husband 10,000 20632 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State M☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Application of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Application of the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Application of the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Self-inflicted gun Shot ressied Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ot as a consequence of): Examiner Due to (or as a consequence of): Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death Check on one Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 은 1√Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 1 Natural

Box P.O. Records, Vital of

MONICA BOWLING

68760 Division death.

Show

hours after

within 24 hours a To the Funeral (

Baltimore, Maryland 21215-0036 Hygiene. other 2 should be fi and Mental H is marked of if of Health of ō permit. Page Department of Importent: If any injury or once. Frank Smith Cemetery 10/18/04 Bristol, Virginia Pnysician /Medical **Examiner** that the death certificate be executed 28b. Time of Injury 17:35 28d. Describe how injury occurred **Self inflicted** Certification: To the Hospitel or Attending 5 Pending investigation 10/10/2004 1744 2 Accident Shot self in head 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f Location (Street and Number or Rural Route Number, City or Town, State) 12146 Catalina Dr. determined 4 \ Homicide **Home** Lusby, MD 1 Carifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Difficult Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1732 OCTOBER 11, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAYMON A. NOBLE, M.D. 32 COX ROAD HUNTINGTOWN, MARYLAND 20639 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 13 2004 Registrar **ORIGINAL**

DHMH 17 Rev 1/2001

			For State Registrar	State of M	-	-	nent of H		Mental Hygie	2004	34745	
			Decedent's Name (First, Middle, L.	ast)					2. Date of Death		3. Time of Death	
	Physicia /Medic		Frederick Willia	m Berens.	Jr.				October	Day Year 14, 2004	7:20 A M	
• • • •	Examin		4a. Facility Name (If not institution, gi			4b.	City, Town, or	Location of Death		4c. County of Dee		
			10500 Rockville	Pike, Apt.	709		Rockvil			Montgome	ry	
	Funeral			Sex 7. Ag 1 X M 2 □ F	ge (In yrs. last birt		Inder 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	rear) Co	thplace (State or Foreign puntry)	
	Director		577-28-9608 Usual Residence of Decedent	4	80	TIS.			10/15/19	923 Wash	nington, DC	
	riand ow		10a. State 10b. County		10c. City, Town	or Location	n				10d. Inside City Limits	
	Man s-f sh	ţoţ	MD Montgome	ry	Rockvil	11e					1 ☐ Yes 2X No	
	th the	Director	10e. Street and Number		-1	10	f. Zip Code		100	g. Citizen of What Co	ountry?	
	23a	al	10500 Rockville	Pike Apt.	709		20852			U.S.A.		
	tams er E	Funeral	11. Marital Status	12. Was Decedent Armed Forces	? ukn	13. Was I	Decedent of Hi , specify Cuba	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
36	s afte	by Fi	1 ☐ Never Married 2 🕅 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:		1 □ Y	es 2X No	Specify:		Specify: Wh	ite	
2-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itams 23a or 28a-f show ent, it e Madical Francement the Indiffical	edt	15. Decedent's I			Decedent's	Usual Occupa	ation	16	6b. Kind of Business	/Industry	
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2		Be (17. Father's Name (First, Middle, Las	,				18. Mother's Nan	ne (First, Middle, Ma	aiden Sumame)un	k.	
<u>ya</u>	2 should be filed within 72 hours atter death with the Maryian and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28a-f show atmatic event, II e Madical Erection or matter rectified at	2	Frederick Willia									
Maryland 2121	12 sh h and 7 Is m traum		19a. Informant's Name/Relationship		11.00					City or Town, State, 2		
e,	1 and Health am 2 thar 1		Frederick Berens 20a. Method of Disposition	, III, Sor	20b. Place of	Disposition	(Name of			C. Location - City or	e, MD 20852 Town State	
nor	ages in of o		1 ☐ Burial 2 X Cremation 3 14 ☐ Donation 5 ☐ Other (Spec		9		y or other place 1 Crem.			rentwood,		
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If itam 27 Is marked any injury or other traumatic avonce.		21. Signature of Fun all Service Lice	•	те. п		ne and Addres		Simple Tr		Maryland	
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			23a. Part1. Enter the disease, or conshock, or heart failure. List only	nplications that cayse	od the death. Do r						Approximate Interval Between	
	Pnysician			Onset and Death 2 years								
	/Medical		disease or condition resulting in death)		2 Jours							
	Examiner	L	Sequentially list conditions,	b								
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8760,	icate be executed physician and s the burial-transit	dical		d								
9	tificat 19 phy as th	a a									-	
Box	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth	e of pregnancy 2 Fetal death	3□Ecto	pic pregnancy			23d. Date of delivery		
Э.	e dea the at ned fo	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□ Unknown	at time of death		er (specify)			Month	Day Year	
P. 0.	d by tetach	Phy		contributing to death	hut not resulting in	the underly	ing cause give	on in Part I	23e Did toba	cco use contribute to	the cause of death?	
ds,	signed be det	d by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute								obably 4 Unknown	
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<u> </u>	\$ s	0 B	examiner? 1 □ Yes 2 🛣 No	Hospital: 1 Inpati	ient 2 ☐ ER/Out	tpatient 3	DOA Othe			ce 6 ☐Other (Spe	cify)	
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Ë		Certification;	3 Suicide 6 Could not 4 Homicide determine	d 286. Place of in	njury - At home, far atc. (Specify)	rm, street, fa	actory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	iral Route Number,	
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			> UKUUKU	ULLYVV	MU)	D2153	31	00	ctober 14,	2004	
			30. Name and address of person wh						-1			
			G. Peter Pushkas			orget	own Rd,	Rockvil	le, Maryl	and 20852		
	Sta Registr		31. Date filed (Month, Day, Year) OCT 18 2		trar's Signature	69	books	/				
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			State of Maryland / De	partment of Health and M	-	ene a	
		•	- FOI	ertificate of Death		No. 2001	+ 34746
	Discolation		Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
¥	Physicia /Medic		Fayetta Gladys Bowers		October	14, 2004 4c. County of Deat	1:20 P
Ž.	Examin	er	4a. Facility Name (If not institution, give street and number) Hillhaven Nursing Home	4b. City, Town, or Location of Death Adelphi		Prince G	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthd		8. Date of Birth (Month, Day, Y		hplace (Stete or Foreign untry)
	Director		505.10.0401 1□M 2♥F 89 Yrs	i. William Days 110013 Will.	July 5,		th Dakota
	land ow	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	Mary a-f sh ffied	tor	Maryland Prince George's Adelph	i			1 🖾 Yes 2 🗆 No
	or 28;	Director	10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	untry?
	ours after death with the Marylan al', or items 23a or 28a-f show Examirar must be notified at		2600 Muskogee Street 11. Marital Status 12. Was Decedent Ever in U.S.	20783	acify Ves or No.	U.S.A.	ocan Indian
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	iled within 72 hours after death with the Maryland Hygiene, Hydiene, wither 12a or 28a-1 show ther then "natural", or items 23a or 28a-1 show ant, the Madical Examinar must be notified at	by	3 ☒ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🖾 No Specify:		Specify: WI	ITCE
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yla	Menta Menta arked	ToE	Paul B. Hackleman			ethe	
N N	12 sh h and 7 is m traum			lailing Address (Street and Number or Rura 0 Muskogee Street,			
ָט ע	Healt tem 2 other		20a Method of Disposition 20b. Place of Di		* -	c. Location - City or	
	Pages nent of nt: # i		1 XI Burial 2 Cremation 3 Hemoval from State	n Memorial Park 10/	18/04 Ro	ckville,	Maryland
מוב	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other then "nature eny injury or other traumatic event, the Madical longs.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility HINES-RINALDI FUNER.	AL HOME		
_	40E # 9			11800 New Hampshire	Ave, Sil		g MD 20904
	Physician		shock, or heart allure. List only one cause on each line.	Cardiovascular Dise			Interval Between Onset and Death 15 Years
	/Medical		resulting in death) ALTIETOSCIETOLIC Due to (or as a consequence of):		450		19 Icais
	Examiner	<u>.</u>	Sequentially list conditions, if any leading to immediate b. Due to (or as a consequence of):				
	uted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury				
00,	e be executed rsicien and e burial-transit	Exa	that initiated events c. Due to (or as a consequence of):				
0/0	ate be hysicii the bu	lcal	d				
00 X	ding p	Physician/Medl	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	n/en/
200	death s atten d for u	Ician	23b. Was decedent pregnant in the past 12 months? 1 Vec. 2 No. 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
	at the by the stache	hys	9 ☐ Unknown				
Z,	The law requires that the death certificate sle has been signed by the attending phys bage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		cco use contribute to	othe cause of death?
cords,	been should	etec			24a. Was an		itopsy findings available
D L	he lav e has age 2	Completed			autopsy performe	prior to death?	completion of cause of
N I G	ian: T	a	25. Was case referred to medical	26. Place of Deatl	1 ☐ Yes 21 (Check only one)	NO I I I I I I I I I I I I I I I I I I I	2 110
> 0	hysic his ce	ToB	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpa			ce 6 Other (Spec	cify)
חכ	ding P	Certification;	27. Manner of Death 28a. Date of Injury 28b. Tim Inju 2 Accident investigation 2 Accident investigation		28d. Describe how	injury occurred	
VISION	Atten	ifica	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)		28l. Location (Stre City or Town,	et and Number or Ru	ıral Route Number,
5	ital or rs afte in Dir	Cert	uniding, atc. (Specify)		City of Yours,		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Attenthis certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one) 1				
	ro the	Med	29b. Signature and title of certifier	29c. License number	290	I. Date signed (Monti	h, Dey, Year)
			> Culling	D-31563	0	ctober 15	, 2004
	7		30. Name and address of person who completed cause of death (Item 23a) (Ty		1205 041	TOP Cond	~ MD 2000/
	Sta	ate.	Charles M. Benner, M.D., 10801 Loc		7203, 511	ver Sprin	g,rm 20904
	Registr		OCT 18 2004 Shave B	poaks			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 200 L 34747 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** French Groom Clark, Jr 2340 M October 2004 12 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil County E1kton Ceci1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** XXM 2□F 221 14 4140 79 Director Sept. 26,1925 Delaware Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2☐No Delaware New Castle Hockessin Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 136 South Colts Neck Drive 19707 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No 1942— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 N Divorced 1946 White "natural", d Mental Hygiene. narked other than "natura natic event, the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Firefighter City of Wilmington 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 27 is marked or traumatic even French G Clark, Sr Frances Pickering 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 I other tra Robert F Clark/Son 136 South Colts Neck Road, Hockessin, Delaware 19707 20b. Place of Disposition (Name of cometery, crematory or other place)
Delaware Veterans
Memorial Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ot once. 1 Donation 5 Other (Specify) Oct.21,2004 Bear, Delaware 22. Name and Address of Facility Crouch Funeral Home 21. Signature of Fundo Service L 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Subdural Hematon **Physician** Acute hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐ Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Lent diabetes, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? and Councilin Therapy 24a. Was an page 2 s certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: Be 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 2 1 XYes 2 □ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: After 1 Natural 5 Pending Injury s after decret al Director: Ate Fell in war singhome Lit
281. Location (Street and Number or Rural Rouse Number,
City or Town, State)

Ellit. 22 October 12 14 1930 M 1 = 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Leured would rest, in farm. 1 ☐ Yes 2 No 2 XAccident investigation 6 Could not be determined 3 Suicide within 24 hours after de To the Funeral Directo completely filled in by th 4 Homicide 100 Lawel Dr., Elkton, MD 21921 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only fo the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) le VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Union Hospital, Elkton HFarkes, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State OCT 2 0 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie Pen 1 1 1 - For Stete Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Cascio **Physician** 20, 8:15ath 2004 Clu October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing and Rehabilitation Center Worcester 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Funeral Days 1 X M 2 ☐ F 71 MD Director 215-30-7762 9/6/1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental hygiene. and if item 27 is marked other than "natural", or items 23a or 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r itams 23a or 28a-f show free must be notified at Y☐Yes 2☐No Be Completed by Funeral Director Ocean City Worcester MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21842 USA 6 90th St. Unit 3 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 【No If Yes, Give 1 Never Married 2 Married Specify: White 1 ☐ Yes 2XXIo Specify: If Yes, Give Year or Dates: other traumatic evant, the Medicul Evar 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Truck Driver Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Harry Samuel Cascio Catherine Imbragolio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6 90th St. Unit 4 Ocean City, MD 21842 Karen Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/25/04 Department of H Important: If its any injury or ot once. 1 Burial 2 Cremation 3 Removal from State Cape Henlopen Crematory Frankford, DE * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility. The Burbage Funeral Home 21. Signature of Funeral Service Licensee 26a. Part1. Enter in disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Cerebrovascular accident with Due to (or as a consequence of): henorrhage Pnysician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ iable KS mellitus 1 Yes 2 No 3 Probably 4 Unknown Completed nupe-tersion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ateydisease Coronary 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ☐ No P 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 🔲 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760. P.O. Records, Division of Vital Hospital or Attending Physician:

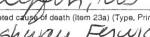
Cascio, Harry Baltimore, Maryland 21215-0036

State

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier



29c. License number (DE) C1-0006795

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISTINE M. GRIFFIN MD Coastal FEWICK Island, DE 19944 huay

there

Registrar

DHMH 17 Rev 1/2001

Registrar

07530

WRTIN Mary

OCT 1 9 2004

			For Stete Registrar		f Maryla	nd / Depa	artment <i>rtificate</i>	of He	ealth a	and M		g. No.) 4	34750		
	sicia ledic		Decedent's Name (First, Middle, THOMAS JOSEPH C	•							2. Date of Deat Month OCTOBER	Day	Year 004	3. Time of Death 6:10 P ^M		
	amine		4a. Facility Name (If not institution, CHESAPEAKE HOSP				4b. City, To			of Death			4c. County of Death ANNE ARUNDEL			
Fund Direc			081-18-9827	.Sex 1 ∑ M 2□F	7. Age (In yrs	o. last birthday) O Yrs.	If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, SEPT. 2,	Year)	9. Birthp Cour	place (State or Foreign		
ite, intal yidalid Z 1Z 13-0030 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Madical Extrainer manuscentilised at	a ricillised at	Director	Usual Residence of Decedent 10a. State 10b. County MD ANNE A 10e. Street and Number	RUNDEL		ity, Town or Lo		ode			10	Og. Citizen of	10d. Inside City Limits 1 □ Yes 2 反 No 10g. Citizen of What Country?			
	Medical Exacility Indal C	ompleted by Funeral D	2600 POINT LOOK 11. Marital Status 1 Never Married Rarried 3 Widowed 4 Divorced 15. Decedent's (Specify only highest	12. Was Dec Armed Fo 1 MYes If Yes, Gin Year or D	12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 \(\) No 1943- If Yes, Give Year or Dates: 1945 cation 16a. Decedent			21401 Vas Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes 21 No Specify: ent's Usual Occupation ind of work done during most of working D NOT use retired)					ce - Americ ck, White, fy: WH	etc. I TE		
2 should be filed within and Mental Hygiene.	Went, Ile	Be Com	12 17. Father's Name (First, Middle, La	est)) +	ENGI	NEER	1	8. Mother	r's Name	(First, Middle, M	ELECTR faiden Sumai				
a. (2 o)	reumence	<u></u>	THOMAS JOSEPH C. 19a. Informant's Name/Relationship	(Type, Print)	···			Street an	d Numbe	r or Aural	ESSLER Route Number,	-		,		
Pages 1 and 2 net: If item 27 i	ry or other		ELIZABETH CARTI 20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 4 □ Donation 5 □ Other (Spe		State	Place of Dispo cemetery, crer ESAPEAK	sition (Name natory or othe	of er place)	I	Da		OLIS, Oc. Location STEVEN	- City or To	wn, State		
permit. Pages Department of	any inju		21. Signature of Funeral Service Li	censee	2	, AI 81	Name and DAMS 01	Address ANI GAT	of Facility NAPOI E ROA	LIS F	UNERAL NNAPOLT	& MEMO	RIAL	CARE		
Physice percented behaviored behaviored by sice and behaviored and behaviored by the second beha	ner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on caph line. Approximate Interval Between													
	cied to use as me of	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Un										23d. Date of delivery Month Day Year			
w requires that been signed be	alan an ning	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobat 1 Yes									acco use contribute to the cause of death?				
sicien: The law recentificate has be	V	Completed									24a. Was an autopsy perform	ed2	Were autop prior to com death? I \(Yes\)	osy findings available appletion of cause of 2 No		
ng Phys fter this		90	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural 5 Pending investigal	28a. Date of (Mont		ER/Outpatien 28b. Time of Injury		Other: Injury at Work?	4 Nursing Home 5 Residence 6 Sother (Specify) 17003					touse		
tel or Atter	in ka iii be	Certification;	3 Suicide 6 Could not be								et and Numb State)	at and Number or Rural Route Number, State)				
To the Hospitel or Attendi within 24 hours after death.	mpioteny an	edical	one)	Physician: To the aminer: On the ba and mann	isis of examin	owledge, death ation and/or inv	estigation, in	my opin	ion, death	place, an	d at the time, dat	e and place,	and due to	the cause(s)		
To with	3		29b. Signature and title of certifier	mill	Su			icense n	183	8	290	Date signed	(Month, D	OOL		
414	Ctoo		30. Name and address of person when Straw E. 31. Date filed (Month, Day, Year)	Selon	e of death (Ite	W	900	Be	stga.	He Ri	d. Anu	napoli	5, 0	ud.		
Roc	Stat	5	OOT 4	F 0004		L	A. a. st									

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3 Time of Death Day Year **Physician** Chambers Leroy October 0 11, 2004 10:15am /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner 5908 Nassau Street District Heights Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days DOM 20 F 577-44-2687 70 Yes July 13, 1934 North Carolina Director Usual Residence of Decedent Pegas 1 end 2 should be filed within 72 hours efter death with the Maryland nant of Health end Mentel Hygiene. Int. of tems 23s or 28s-1 show int: If item 27 is marked other than "natural", or trems 23s or 28s-1 show 10a State 10c. City, Town or Location 10d. Inside City Limits frems 23a or 28a-f shoriner must be notified at tyEl Yes 2 □ No Funeral Director Maryland Prince George's District Heights 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 5908 Nassau Street 20747 United States Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U,S.
Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Armed Forces?

DEYes 2 No 1958
If Yes, Give
Year or Detes: +0 1960 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 € No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cottege (1-4or 5+) Carpentry Private 12 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Dora Harrell 2 Ben Chambers 19a. Informant's Name/Relationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vanessa Chambers / Wife 5908 Nassau Street District Heights, Md. 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 10/18/04 Cheltenham, Md. 21. Signature of Funerat Service Licensee 22 Name and Address of Facility Alexander S. Pope Funeral Homes, P.A. 5538 Marlboro Pike/Forestville, Md. 23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each tine. Approximate tnterval Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) CARDIORESPIRATORY FAILURE /Medical Examiner Examiner physician and the bunal-transit or Attending Physicien: The law requiras that tha death certificete be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last umour Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part t. 1 ☐ Yes 2 Ho 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy performed? 1 □ Yas 2 ≥ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Q Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification: To 1 ☐ Yes this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: Aft completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature end file of certifier 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) "Landover Road, Cheverly MD 20785

State Registrar 31. Date filed (Month, Day, Year) 1 9 2004

LIPISHREE

2. Registrar's Signature

			1 - For State Registrar	State of N	Marylan		artmen rtificat			and M		giene 0	04	34752	
	Physici	an	Gary Wayne Courville October 13 2004 6.									3. Time of Death			
}	/Medio Examin		4a. Facility Name (If not institution, give	give street and number) 4b. City, Town, or Locat						of Death	ocase		13 2004 6:25 p		
			919 Gahle Road						inste				rroll		
	Funeral Director		212-52-55/9	ex 7.7 XIM 2□F	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bir (Month Da April	18°1958	9. Birthp Cour	lace (State or Foreign htry) MD			
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits	
	e-fsh	ctor	MD Carroll Westminster											1 ☐ Yes 2 🗖 No	
	with the	Funeral Director	10e. Street and Number 10f. Zip Code 21157									10g. Citizen of		ntry?	
	death ms 23.	erai	919 Gahle Road	12. Was Deceder	nt Ever in U	.S. 13.	Was Deced			gin? (Spe	ecify Yes or No Rican, etc.)	- 14. Rac		American Indian,	
020	ours after rai', or ite Exemina	þ	1 🔀 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Force 1 ☐ Yes 2 2 If Yes, Give Year or Dates	₫No		1 Yes, spec 1 ☐ Yes		n, Mexican Specity:	, Puerto	Rican, etc.)	Specif	ck, White, ^{'y:} Wh	ite	
ם ה	"natu	etec	15. Decedent's Ed (Specify only highest gra	ducation de completed)		16a. Dece	kind of wo	rk done o	lurina most	of worki	ng	16b. Kind of B	usiness/In	dustry	
7	iene.	Completed	Elementary/Secondary (0-12)	College (1-4o	r 5+)	ilfe. i	no notus Help)			Food	Indus	trv	
Idila	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28e-f show or other treumatic event, the Medical Examinar must be notified at	To Be C	17. Father's Name (First, Middle, Last) Darrison Courvil		100				(First, Middle, t Alber	Maiden Suman					
Mary	d 2 th a tre	-	19a. Informant's Name/Relationship (19b. Mailir						er, City or Town,		Code)	
e G	es 1 au of Hea fitem r othe		20a. Method of Disposition 1 ABurial 2 Cremation 3			Place of Dispo	sition (Nar	ne of ther place	9)	C	ate	20c. Location -	City or To		
Dallillor	mit. Pages vartment of i vortant: If it injury or o		' 4 ☐ Donation 5 ☐ Other (Specific	y)	Our	Lady	of th	ne Fi	elds	10/	16/2004	Miller	svill	e, MD	
ם ח	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licer	en	CIIC	4	12 Wa	d%∆ddres ashir	s of Ferrina ngton	Ltts Road	Funera d West	l Home a	and C	hapel, PA 21157	
	Physician /Medical		23a. Part1. Enterme disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caus one cause on each PLI a	MA	24	173	e of dying	`	cardiac o	r respiratory a	CA)	Approximate Interval Between Opeet and Death	
	Examiner	Jer.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a		,									
9,00,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	dicai Examiner	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):												
OX OQ	certifica Iding ph	/Medi	IF FEMALE:	23c. If yes, outcom	ne of pregna	ancv						024 D			
	the death by the atter ached for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	at time of d		Ectopic pr Other (sp						te of delive onth	Day Year	
ras, r	w requires that the s been signed by th should be detache	by	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to			e cause of death?	
Hecord	> 11 (7)	Completed									24a. Was autop perfo	sy	prior to con death?	osy findings available	
<u> [a</u>	ien: T rtificat tor, pa	0	25. Was case referred to medical						26. Place	of Death	1 ☐ Yes (Check only o		1 🗆 Yes	2 4 10	
>	hysic his ce	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatien	t 3 DC	A Othe				•	er (Specify)	
0	anding Plath. or: After the	ertification:									28d. Describe h	low injury occurr	red		
DIVIS	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.	Certific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route No. City or Town, State)									Route Number,			
29a. Certifier (Check of yone) 29a. Certifier (Check of yone)									cause(s) and ma date and place,	inner as stand due to	ated. the cause(s)				
	Tott Tott	Me	29b. Signature and title of certifier	into	M	1)	29c	License	number	39	8	29d. Date signed	d (Month, L	Day, Year)	
	wo		30. Name and address of person who	completed cause of	death (Item	n 23a) (Type,	Print)	CI	col :	1 8		1017	0 1 1	. ¬	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Regis	ntrar's Signa	luto	CUTC	J	act	ue	THILD'S	a, MD	2115) [
•	Registr		OCT 1.8	2004	Parece -	K	Coast	10							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 1 - For Stata Ragistras 34753 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 16 2004 Vear **Physician** Wilma Florence Coster Oct 4:00 A M /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Calvert Lusby 1879 Coster Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. April 15 9. Birthplace (State or Foreign New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Ye}17918 1 ☐ M 2 ☐ F 115-09-3148 86 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 28a-f show other traumatic evant, the Medical Exercities nest be notified at Lusby Maryland Calvert 1 ☐ Yes 2 XNo Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with ö 20657 United States 1870 Coster Road Items 23a Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant of Health and sarked other than "natural", or flems 23. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 ☐ ★o Baltimore, Maryland 21215-0036 Specify: white Specify: 3 ₩idowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilhelmina Siegle Edwin Parker Cole ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) P.O. Box 708 Cullowhee NC28723 Sandra H. Hardy- niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) Oct 23 2004 ö Department of important: if any injury or once. St. Peters Cemetery Lusby Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Rausch Funeral Home 20676 4405 Broomes Is. Rd. Port Republic MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death breast cancer Immediate Cause (Final Physician 7 morte disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate the first cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. physician Physician/Medicai the IF FEMALE esn 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? ō 4☐Pregnant at time of death 5 Other (specify) P.O. he 9 Unknown þ signed to be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 No Other: 2 1 Tyes 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After Hospital or Attanding 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Diractor: 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funarai TS-Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature an 04 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day Year) 32. Registras Signature State 19 2004 ▶ Registrar

			1 - For State Registrar	State of	Maryland	/ Depa	artment <i>rtificate</i>	of H of L	ealth : Death	and M	lental Hyg F	jiene 0	04	34754
	Dhusis		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medi		Joan Ann (Compton							October		004	5:20 A ^M
	Examir	_	4a. Facility Name (If not institution, Calvert Memori				4b. City, T		Location Fre		ck		ity of Death Calve	
	Funeral Director		216-28-8807	5. Sex 7. 1 ☐ M 2 🔼 F	Age (In yrs. las	t birthday) Yrs.	If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day May 31	1933	_Cou	place (State or Foreigr intry) nnsylvania
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, 1	Fown or Lo	cation							10d. Inside City Limits
	Manylis f sho	ö	MD Calv	zert		nting								1 ☐ Yes 2 🛣 No
	the t	rect	10e. Street and Number	, ст с	110		10f. Zip (Code				10g. Citizen o	f What Cou	intry?
	3a or	D	4420 Solomons	Island Ro	ad			206	39			-	J.S.A	*
21215-0036	s 1 and 2 should be filled within 72 hours after death with the Maryland if Health and Mental Hygiene. tiem 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Madical Exertifier 1.	d by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Nover 4 Divorced	12. Was Decede Armed Force d 1 Tyes 2 If Yes, Give Year or Date	es? ☑ No	1	Was Decede f Yes, specif	fy Cubai	spanic Or n, Mexical Specify:	n, Puerto	ecify Yes or No- Rican, etc.)		ack, White	can Indian, , etc. White
15-0	"natu	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual kind of work DO NOT use	done d	lurina mos	t of work	ing	16b. Kind of	Business/II	ndustry
12	12 should be filled within h and Mental Hygiene. Y is marked other then "raumatic event, InalMac	dwc	Elementary/Secondary (0-12)	College (1-4	or 5+)		Homem:					Ov	n Hor	ne
	i filled t Hygi other ent, I	BeC	17. Father's Name (First, Middle, L.	as <i>t</i>)					18. Moth	er's Name	e (First, Middle,			
Maryland	Aenta Aenta rkad tic ev	To B	Stanley			Vine	ski, S	Sr.	Ma	ry			Pri	ice
lary	2 shor	-	19a. Informant's Name/Relationshi			19b. Mailin	ng Address ((Street a	ind Numb	er or Run	al Route Numbe	r, City or Tow	n, State, Zi	p Code)
	and and m 27		Karen Phillip	s (daught			Solomo		Isla			ntingto		
Baltimore,	Pages 1 nent of Hi ant: If iter ary or oth		20a. Method of Disposition 1 ☐ Burial 2 A Cremation	B □Removal from Sta	ate cem	etery, cren	sition (Name natory or oth	ner place	e)	0ct	18	20c. Location	n - City or T	own, State
Ë	tmen tent: jury		`4 □Donation 5 □Other (Spe	ecify)	Lee		atory			20		Clint		
Ba	permit. Pages 1 and 2 Department of Health Importent: If item 27 any injury or other tra once.		21. Signature of Euneral Service Li								e Funera land Blv			vert, PA MD 20736
68760,	Physician / Medical Examiner bhysician and bhysician and street physician and street transit transit	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or	as a consequer as a consequer as a consequer	nce of):	Pulmo		<i>"</i> (G 123				
O. Box	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Fetal de nt at time of deat	eath 3	Ectopic pre						ate of deliv	ery Day Year
Records, P.	uires that signed b d be deta		Part II. Dther significant condition	s contributing to deal	th but not resulti	ng in the ur	nderlying car	use give	n in Part I		23e. Did to	1		he cause of death?
COL	w requir been si should	Completed									24a. Was a	ıp. 24h	Were aut	opsy findings available
Re	The fa ate has page 2	dmo									autops	med?	prior to co death?	mpletion of cause of
ta	en: T tificat tor, pa	a	25. Was case referred to medical						26 Place	e of Deat	1 Yes	No No	1 🗆 Yes	2 2 No
of Vital	Physicien: this certificaral director, p	To B	examiner? 1 Tes 2 No	Hospital:	patient 2 EF	VOutpatien	t 3 DOA	Othe	ir-		me 5 Resid		ther (Speci	fy)
	ttending Ph death. ctor: After th y the funeral		27. Manner of Death 1. Matural 5 Pending 2 Accident investigs		Injury 28 Day Year) 28	Bb. Time of Injury	28 M	ic. Injury Work			28d. Describe h			,
Division	al or Attending safter death. I Director: After d in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of	f Injury - At home , etc. (Specify)	e, farm, str	eet, factory,	office			28f. Location (S City or Tow		nber or Rur	al Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one) Certifying 2 Medical E	Physician: To the be xaminer: On the bas and manne	is of examinati <i>o</i> r	edge, death n and/or inv	n occurred a vestigation, i	t the tim	e, date ar inion, dea	nd place, ath occurr	and due to the cred at the time, c	ause(s) and n late and place	nanner as s , and due t	stated. o the cause(s)
	within To th	Me	29b. Signature and title of certifier	01			29c.	License	number		2	9d. Date sign	ed (Month,	Day, Year)
			1 298	and			10	747	610			octeb	Pho	17,2014
	5		30. Name and address of person w	no completed cause	of death (Item 2:	3a) (Type,	Print)	0 :	200	78	Dr. D	avid		dio MD
ľ	St	ate	31. Date filed (Month, Day, Year)	32. Reg	pistra s Signatur	0		40				24100	1000	70,00

State of Maryland / Department of Health and Mental Hygien 34755 1 - For State Registre Certificate of Death Reg. No. 2. Date of Death 3 Time of Death Decedent's Name (First, Middle, Last) **Physician** A M October 13, 2004 9:03 Innes Margaret Croggon /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Bowie Bowie Health Care Center 8. Date of Birth (Month, Day, Yea If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 28, Yrs. 1924 Australia 80 May Director 578-54-8809 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygierie. and the state of Health and Mental Hygierie and the state of teams 23a or 28e-1 show and: If item 27 Is marked other than "naturel", or items 23a or 28e-1 show and the required sevent, Item Madical Eruchi at Industical Expension of the prefitted at 1 ☐ Yes 2 ☑ No Directo Lanham-Seabrook Maryland Prince Georges 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 20706 U.S.A. Be Completed by Funeral 9418 Worrell Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2√ If Yes, Give X Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√⊡ No Specify: 3 □XVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Home Maker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Beatrice Annie White Raynor Joseph Hargreaves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 57 Harwood Maryland 20776 Owen Walter Croggon/ Son 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cometery, crematory or other place)
Maryland
Veterans Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Department of Important: If any injury or once. 10/18/2004 Cheltenham, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home DEL 16000 Annapolis Road Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 30 Minutes Cardiac Arrest /Medical Due to (or as a consequence of): **Examiner** 30 Minutes Ventricular Tachycardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed 14 Years Arteriosclerotic Heart Disease Due to (or as a consequence of): Box 68760 Physician/Medical d. IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown Alzheimers Disease Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 2√□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 NOther (Specificate Center Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐XNo 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death e Hospital or Attending Pl 24 hours after death. e Funeral Director: After th Certification: 5 Pending investigation 1 Xatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a: To the Funeral Completely filled in 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier CYON 10/13/04 D0016197 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andres C. Lara M.D., P.A. 9326 Lanham Severn Road Lanham, Maryland 20706 strar's Signature State 5 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 34756 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** John Lawrence Clark, Jr. 13 Oct 2004 250 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert County Nursing Center Prince Frederick Calvert If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 M 2 □ F Months Days Hours 61 212 42 5984 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at Calvert Huntingtown Maryland 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20639 United States 4165 Huntingtown Road Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck driver/ salesman retail sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once</u>. John L. Clark, Sr. Eloise Buckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance E. Clark - wife 4165 Huntingtown Rd. Huntingtown MD 20639 20b. Place of Disposition (Name of cometery, crematory or other place) Oct 16 2004

Huntingtown UMC Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Huntingtown Maryland 1 Murial 2 Cremation 3 Removal from State ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic mD 20676 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Cazanoma Immediate Cause (Final Proslate Physician disease or condition resulting in death) /Medical en Due to (or as a consequence of): Examiner 117 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical the use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2. No 3 Probably 4 Unknown 1 ☐ Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s has certificate 1 Yes 3/2 No 25. Was case referred medical examiner? 26. Place of Death Check on vone Certification: To Be Other: Hospital: 1 Yes 4 ursing Home 5 Residence 6 Other (Specify) 2 2 0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Min of Death 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After or Attending 5 ☐ Pendina after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause death (Item 23 (Type, Print) Hospital Ra Munsh 31. Date filed (Month, Day, Year) 32. Registra s Signature State 5 2004

DHMH 17 Rev 1/2001

Registrar

	1	For State Registrar	State of Ma	ii yiaiiu /		rtificate of			Reg. No	2 N N I.	347	5
ysician Medical	3	Decedent's Name (First, Middle, Last David Brooks Cro						2. Date of Da. Month Octobe	Day	y Year 3, 2004	3. Time of 1:10	Death A ^N
aminer		4a. Facility Name (If not institution, give	street and number)				or Location of Dea	th		County of Dea		
eral		Anne Arundel Med: 5. Social Security Number 6. S		L' (In yrs. last b	irthday)	If Under 1 Year		8. Date of Birt		nne Aru	thplace (State or ountry)	r Forei
ctor	-	578-50-9369 Usual Residence of Decedent	ex 7. Age 7. Age 6.	5	Yrs.	Months Days	Hours Min	8. Date of Bin (Month, Da 10-20-	1938	Was	shington	, D
fled at		10a. State 10b. County Maryland Anne Art	undel	10c. City, Tov		polis					10d. Inside Cit	-
Director	2 2	10e. Street and Number 3014 Friends Road				10f. Zip Code 214	01		10g. Cit	izen of What C	ountry?	
Firmeral	- E	11. Marital Status	12. Was Decedent E	ver in U.S.	13.		Hispanic Origin? (Span, Mexican, Puer	Specify Yes or No	-	14. Race - Am	erican Indian,	
2	בֿב	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 242 N If Yes, Give Year or Dates:	lo		1 ☐ Yes 2 🔀 No		по нісап, етс.)		Black, Whi		
olea Peter	bierer	15. Decedent's Ec (Specify only highest gra			(Giva	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	16b. K	ind of Business	/Industry	
ft, the	5 -		5+		En	gineer		(27)			Engine	er
ic even	٥	17. Father's Name (First, Middle, Last) Samuel Stewar						_{lme (First, Middle,} argaret]	_	,		
tam T	-	19a. Informant's Name/Relationship (7		19	b. Mailir	ng Address (Stree	t and Number or R				Zip Code)	
ner tre		M. Diane Cross/ W	ife			Friends	Rd., Ani	napolis,	MD :	21401		
any injury or other tree		20a. Method of Disposition 1 ☐ Burial 2XXX remation 3 ☐	Removal from State	cemet	ery, crer	osition (Name of matory or other pla		Date		ocation - City or		7
injury		 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Septice Licen 		Kalas		ematory 2. Name and Addr	ess of Facility G	15-04 eorge P.			Marylaı ral Home	
orny ir		> West Much	w				mone Isla	_				
cian lical		23a. Part1. Enter the disease, or compands, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	olications that caused one cause on each lin a	ny C	911	er the mode of dy	ing, such as cardia	ic or respiratory ai	rrest,		Approximate Interval Betwoen Onset and D	veen Death
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ne burial-transit		cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):							
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should be detached for use as the letter hy Physician/Medi	Iysician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal deat		Ectopic pregnand Other (specify)	эу			23d. Date of de Month		'ear
<u>۾</u> ۾	2	Part II. Other significant conditions o					iven in Part I.	23e. Did to			o the cause of de	
N C	naidino	•						24a. Was autop perio 1 Yes		prior to	utopsy findings a completion of ca	ivailal iuse d
rector, pag	ນ	25. Was case referred to medical examiner?						ath (Check only o			3 2.110	
P P	2	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	Hospital: 1 Inpatier 28a. Date of Injur (Month, Day)		utpatier Time of Injury	f 28c. Inju	ury at ork?	Home 5 Resident			ocify)	
ed in by the funera	eruncar	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined			farm, str]Yes 2□No	28f. Location (S City or Tox			ural Route Numb) <i>01</i> ,
completely filled	edical	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exam	ysician: To the best oniner: On the basis of and manner sta	examination a	ge, death und/or in	h occurred at the t vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner a	s stated. e to the cause(s)	-
5 T	Z -	29b. Signature and title of certifier				-	se number			e signed (Mon	-	
complet		2/1/-	> /1			1110	16/1/11	-	1	1 1	- 13	
complet		• //	1			000	51301		ENVI	ber 14	6004	

State of Maryland / Department of Health and Mental Hygier 004 34758 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Clarke 14,2004 Ctobe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Doctor's Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Sept. 2, 1930 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min Yrs. Director 215-26**-**2847 74 Indiana Usual Residence of Decedent death with the Maryland 10a. State iam 27 is marked other than "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Prince Georges YOS 2□No Bowie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5106 Church Road 20720 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 72 hours after Affiled Folces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No ģ 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed withIn 7. th and Mental Hygiene. 7 Is marked other than "n. Prince Georges Board Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria of Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Chester Payne Ruth Cleo Butt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: if itam 27 is n any injury or other traun Lillian Clarke 175 Croatan Lane New Bern, NC 28562 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 10/18/2004 Lakemont Memorial Gardens Davidsonville, MD 22 Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition BLADDER chicor resulting in death) HTINOM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the entire Cause (Disease or injury that initiated events MOSOCOMIVE NEVTROPERIN Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physiclan and ched for use as the burial-transit 20 SPSIS resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Division of Vital 1 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident Diractor: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Thomicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D55559 DOCS , 21 SERBOTSO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS E. MASUN, M.D. #316 GREENWA CENTUR DR GREENBUT MD 31. Date filed (Month, Day, Year) 32. gistrar's Signatui State Registrar

			State of Maryla State of Maryla 1 - For Amend Item 24a per verb. RegistrarAMFND ITEM #23a, 25, 27&28	ind/Depa ,G837,I	rtment of H	ealth and	Mental Hyg	giene 00	4 34759
	Physicia		Decedent's Name (First, Middle, Last) Janet DeWolff Crevensten			, , , , , , , , , , , , , , , , , , , ,	2. Date of Dea Month September	th Day `	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat		4c. County o	
			THE MEMORIAL HOSPI	TAL	EA	4570N		7	LBOT
	Funeral		4 T 11 2 T 1	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day	(Year)	Birthplace (State or Foreign Country)
'n.	Director		212-01-7249 1 M 2 M 3 M 88 Usual Residence of Decedent) F15.			July 24	1, 1916	Maryland
	/land			City, Town or Lo	cation				10d. Inside City Limits
:	e-fsh illied	tor	MD Talbot		Ea	ston			1 XYes 2 ☐ No
3	or 28	Director	10e. Street and Number		10f. Zip Code			l0g. Citizen of Wh	nat Country?
:	am w		501 Dutchmans Lane			21601		U.S.A.	
	ttems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces? 1 Never Married 2 Married 1 Yes 2 X No	U.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Hace Black,	- American Indian, White, etc.
50	urs an	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	I□Yes 2又 No	Specify:		Specify:	white
2-003d	illed within 72 hours after death with the Maryland Hygiene. Wither than "natural", or items 23a or 28e-1 show ent, the McCraf Examinar must be notified at	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupa	ation	rkina	16b. Kind of Bus	iness/Industry
V	e e e	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. L	NOT use retired homemak)	, , , , , , , , , , , , , , , , , , ,	or mark	ama
7	be filed with ital Hygiene. id other than event, ITE N		17. Father's Name (First, Middle, Last)		nomenak		me (First, Middle,	own h	
Ξ.	e d ala	o Be	William H. DeWolff				Wilson	walden Sumame,	,
5	s 1 and 2 should be f Health and Mental item 27 is marked (other treumatic ev	ပ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street a			r, City or Town, S	tate, Zip Code)
=	2 # Z # Z		Jane Phillips daughter	P. O.	Box 27,	Fishing	Creek, M	D 21634	
O			20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State	o. Place of Dispo- cemetery, cren	sition (Name of natory or other place	θ)	Date	20c. Location - C	ity or Town, State
Ĕ	o = o		'4 □ Donation 5 □ Other (Specify) Ma		Veterans		22/04	Hurlock	
Saltimor	permit. Page Department of Importent: If eny injury or pnce.		21. Signature of Funeral Service Licensee		Name and Addres				
_			23a. Part1. Enter the disease, or complications that caused the de		00 Locust				Approximate
	Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a cons	sequence of):	INJURIES			nc)	Interval Between Onset an Death
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ň	death e atter d for u	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown 23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of 9 □ Unknown	etal death 3 [Enterplic or on ancy Other (s ify)			23d. Date Monti	-
	res that the igned by the be detache	by Ph	Part II. Other significant conditions contributing to death but not r	resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
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ř	The ate h page	Completed					24a. Was a autops perfori	ned? pri	ere autopsy findings available or to completion of cause of ath?
<u> </u>	Physicien: r this certific ral director,	Be	25. Was case referred to medical exampler? Hospital:	/	Otho		ath (Check only or		
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	of the land	tion	→ SHatural 5 Pending (Month, Day Year)	> Injury	Work	(? Yes 2 MNo	Fell and h		
DIVISION	Attending ir death. ector: After by the fune	ertification;	3 Suicide 6 Could not be 28e. Place of Injury - At	t home, farm, stre			28f. Location (Si	reet and Number	or Rural Route Number,
Ē	el or safter		4 Homicide determined building, etc. (Spe		ore		City or Town		EASTON, MD
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	calC	29a. Certifier (Check only 2 ☐ Medical Examiner: On the bast of my k	knowledge, death	occurred at the tim	ne, date and place	, and due to the c	ause(s) and mann	ner as stated.
	the F the F the F	Medical	one) and manner stated.						
	vitl To	M	29b. Signature and title of certifiler	9		9135		69-1	Month, Day, Year) 9^2004
			30. Name and address of person who completed cause of death (II	tem 23a) (Type, 15 Bloom	^{Print)} Adetu ingdale A	ınji Ades Ave., Fed	sanoye M deralsbur	1.D. 19, MD 2	21632
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sig	gnature	4			_ 	
	Regist	rar	OCT 2 8 2004 Sendera	B B	oaks				

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xamin	er	4a. Facility Name (If not institut	_						Location of				County of D		
ineral		Washington A 5. Social Security Number	6. Sex	7	spital 7. Age (In yrs.	last birthday)	If Under	1 Year	Park If Under 2	4 Hrs.	8. Date of Birt	h	Montgo	omery Birthplace (Sta	te or Forei
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r then "natur	Completed	15. Deced (Specify only high Elementary/Secondary (0-12	est grade		4or 5+)	16a. Deced (Give life. L	lent's Usual kind of work DO NOT use	Occupa k done di e retired)	tion uring most	of workir	ng	16b. Ki	nd of Busine	ss/Industry	
		17. Father's Name (First, Middl	e (ast)	2		Home	emaker		10 Mathor	do Nome	/First Middle	Maidan	Own	Home	
9 6	To Be										(First, Middle,	Maiden			
umat	F	Shan 19a. Informant's Name/Relatio	Cai nship <i>(Typ</i>			19b. Mailin	g Address ((Street au	Ying nd Number		Mei I Route Numbe	r, City or	Lin Town, State	e, Zip Code)	
Importent: If item 27 is mark any njury or other traumatic once.		Sonya Z.C. Li 20a. Method of Disposition 1	n 3 □Re (Specify)	emoval from St	20b. P	lace of Disposemetery, crem	sition (Name natory or oth	e of her place	neter	D. v 10	e #512 ate /21/200	20c. Lo	cation · City	or Town, State	Min
any n		21. Signature of Funeral Sarvio	KI	tu	de	22 	. Name and L800 1	Address	of Facility Hamps	Hin hire	es Rina Ave Si	ldi lve	Funer	al Home	5
ician	102	23a. Part1. Enter the disease, shock of Heart failure. Li Immediate Cause (Final disease or condition	or complic st only one	ations that cause on each	ch line.	Do not ente	1	of dying	, such as c	ardiac o	r respiratory arr	est,	-	Approxim Interval E Onset an	Between
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the bu	dicai		d.	COR	ONAR	y A	RIG	RY	Disc	e ASE	-			YEAR	25
detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23		th 2 Fetal nt at time of de	death 3 🗌	Ectopic pre- Other (spe-					2	3d. Date of o	delivery Day	Year
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96.2	Completed		Dio.	GENIC TES	2 St	10 CK					24a. Was a autops perform	ned?	prior to death	autopsy finding o completion of ? es 2 1 No	s available cause of
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funeral	1 Yes 2 No						c. Injury a Work?	at Nuis	2	le 5 ☐ Reside 8d. Describe ho			pecify)		
completely filled in by the	Certification:	3 Suicide 6 Coul 4 Homicide dete	d not be mined	28e. Place of building	f Injury - At ho g, etc. <i>(Specily</i>	me, farm, stre	et, factory,	office		2	8f. Location (St City or Town	reet and , State)	Number or i	Rural Route Nu	imber,
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	Σ	29b. Signature and the of centr	ier		1		29c.	License			2		-,	nth, Day, Year)	
8		- 1/4/1/			/ S		1	1 /6	555/			12	1/14/	104	
200	-	30. Name and address of person	1801	M.	<u>ال</u> الم	23a) (Type, F		7 / 6					1141		

		1 - For State Registrar	State of Maryland /	Depa Cer	rtment of H	ealth and <mark>I</mark> D <i>eath</i>	Mental Hygie	ene 200	4 34761
		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physi		Rita P. Canard					October	Day Yeer 15, 2004	
Exam	dical niner	4a. Facility Name (If not institution, give si	reet and number)		4b. City, Town, or	Location of Death		4c. County of De	
		Hillhaven Nursing	g Home		Ade1	phi		Prince	George's
Funera	al	5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	9. B	irthplace (State or Foreign Country)
Directo		Usual Residence of Decedent	W 2X 30	Yrs.			Nov. 27,	1913 V	irginia
land w		10a. State 10b. County	10c. City, To	wn or Loc	ation				10d. Inside City Limits
Many	ğ	Maryland Montgomer	cy Silve	r Sn	rino				1X Yes 2 □ No
r 28a	Je C	10e. Street and Number	9 11140	<u> </u>	10f. Zip Code		10g	. Citizen of What C	Country?
h witi	a C	1113 West Nolcrest	Dr.		209	03		USA	
dea	Funeral Director	11. Marital Status	Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (S	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
or it	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 📉 No If Yes, Give		☐Yes 2X No	Specify:	, , , , , , , , , ,	Specify:	White
hours tural	d b	3 ₩ Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	a Doord	ent's Usual Occupa	ution	10		
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othe other	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, Ma		8
uld by Menta	To E	Robert L. Pearson		_		Katie	Herrel1		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene and Information of Health and Mental Hygiene. The marked other than "natural; or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examilities must be rightfied at		19a, Informant's Name/Relationship (Typ	e, Print) 19	b. Mailin	g Address (Street a	and Number or Ru	ral Route Number, C	ity or Town, State,	Zip Code)
and and tealth om 27		James E. Canard, Jr			cean Park	way Berl	in, MD 21	811 c. Location - City o	a Tours Ctate
nt of h	0	1 XBurial 2 ☐ Cremation 3 ☐ Re	cemet	tery, crem	atory or other place emetery	'	/2004 Ma	,	
iit. Po		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License					es-Rinald		
Dep	o o	Johnson &	(1) 1/2						ng, MD 20904
		23a. Part V. Enter the disease, or complic	ations that caused the death. Do					-	Approximate
Pnysicial		shock, or heart failure. List only one Immediate Cause (Final	a causa on aach lina. Alzheime:	r's I	Disease				Interval Between Onset and Death 5 Years
/Medica	al	disease or condition resulting in death)	Due to (or as a consequence	e of):					
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ificate g physics the last the	edicai	. d.							
eath certific attending p	Z	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy		F-A:-			23d. Date of de	alivery
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w require been si should b	eted						1 🗆 Yes	2101N0 3 F	Probably 4 Unknown
e law has t	Completed						24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
							1 Yes 2 □		s 2 No
sicial certi	o Be	25. Was case referred to medical examiner? 1 Yes 2 XNo	ospital: 1 Inpatient 2 ER/C	Liteations	3□ DOA Othe		th (Check only one)	- C []Other (G-	- 10.
Phys er this eral di		27. Manner of Death	28a. Date of Injury 28b.	. Time of	28c. Injury	at	ome 5 Residence 28d. Describe how		эспу)
nding F ath. r: After e funera	atio	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work M 1 □ Y	? (es 2 □ No □			
of or Attending Physician: after death. Director: After this certific d in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	et, factory, office	***************************************	28f. Location (Stree City or Town, S	t and Number or F	lural Route Number,
itel or irs aft									
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	(Check only 2 Medical Examin	cian: To the best of my knowled er: On the basis of examination a	ge, death and/or inv	occurred at the tim estigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.		29c. License			Date signed (Mon	
T with		Muller	unce			D31563	30		15, 2004
(0		30. Name and address of person who cor	npleted cause of death (Item 23a	i) (Type. F	Print)				
		Charles Benner, M.				Silver S	pring, MD	20901	
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signature	14	Sports	1			
Regis	strar	OCT 18 200	100	Marie	MIGHER				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 34762 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician OCTOBER 15 2004 CATHERINE RITA DESIDERIO 6:55p /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Chestertown

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months | Days | Hours | Min. | Nov 8 1908 Kent <u>Chester River Manor</u> 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖔 F Yrs. Director 95 Pennsylvania 173-22-2505 Usual Residence of Decedent with the Maryland 10b. County 10a. Sfate 10c. City. Town or Location 10d. Inside City Limits 28e-f show in than "natural", or Itema 23e or 28e-f shov The Medical Examiner must be notified at 1 Yes 2 No MD Kent Galena Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 107 West Cross St. 21635 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examinat once. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White δ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Retail Elementary/Secondary (0-12) College (1-4or 5+) Credit Manager Department Store 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Salvatore Procopio Rose Procopio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) 14115 Park Rd. Kennedyville, MD. 21645 Jeanne Cecilia 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Shrewsbury Cemetery 10/19/04 Kennedyville, MD. 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Littinse Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 23a Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demantia Physician 4041 /Medical Due to (or as a consequence of): **Examiner** Sequentially lisf conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 🗆 Unknown ate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ brovascular arteriosclarosi 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 110 Physician: 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Hospital or Attending Pt 24 hours after death. Funerel Director: After th 27. Mannet of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital within 24 hours a To the Funerel L 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Donaher, MD

119 C.

00058824

North Main St. Galena, MD. 21635

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	State of Maryland	Cer	tificate of L	Death	Ri 2. Date of Deat	ig. No.) 4	34763
Physici	an	1. Decedent's Name (First, Middle, La	•				Month	Day	Year	3. Time of Death
/Medic		JOHN FREDERICK 4a. Facility Name (If not institution, gin			4h City Town or	Location of Death	OCTOBER	4c. County	2004	10:34a M
Examin	er	CRANSVILLE RO			OAKLAND	Location of Godan			RETT	
Funeral		5. Social Security Number 6. S		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birtho	lace (State or Foreign
Director		304-22-2314	1X M 2□F 80	Yrs.	Months Days	Hours Min.	AUG 18,	1924	IND	LANA
pur *		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
Aaryli f sho	ō	MD GARRETT		AKLAND					'	1 ☐ Yes 2 🖾 No
the N	Director	10e. Street and Number	0.		10f. Zip Code		11	Og. Citizen of	What Coun	try?
3a or	Ī	125 STAG RUN			21550)		USA		•
death	Funeral	11. Marital Status	12. Was Decedent Ever in U.: Armed Forces?	S. 13. \	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-		ce - Americ	
be filed within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23s or 28s-f show event, I're Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Tyres 2 No If Yes, Give Year or Dates: WWII		Yes 2 No	Specify:	nican, etc./	Specif	ck, White, y: WH]	
2 hou	ted	15. Decedent's E	ducation	16a, Deced	ent's Usual Occupa	ation		16b. Kind of B	usiness/Ind	dustry
thin 7.	Completed	(Specify only highest gri	ade completed) College (1-4or 5+)	(Give life. L	kind of work done of OO NOT use retired	during most of work)	ring			
filed within Hygiene. other then "	Corr	12	,	MA	NAGER			RESTA	URANT	
	To Be	17. Father's Name (First, Middle, Last CLAUDE	DRAGOO	SR.		18. Mother's Nam MILDRE	e (First, Middle, M D		ne) nknow	n
s 1 and 2 should be f Health and Menta item 27 is markad other traumatic ev	Ĕ	19a. Informant's Name/Relationship	Type, Print)	19b. Mailin	g Address (Street a	and Number or Rur	ral Route Number,	City or Town,	State, Zip	Code)
nd 2 lith a 27 is r tra		WILLIAM DRAGOO -	- SON	RT.	1 BOX 16	1A ACM	E, PA 15	610		
		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐		ace of Dispo	sition (Name of natory or other place	θ)	Date	20c. Location	City or To	wn, State
Pages nent of ent: if it ury or o		1 ☐ Burial 2 Locremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	Jaemovai irom State		MATORY	10/2	1/04	MORGAN	TOWN,	WV
permit. Page Department of Importent: If any injury or once.		21. Signal to o Funeral Service Lice	M0016	1	Name and Addres	•	P.O. - OAKLA	BOX 24:	3 2155	0
Physician /Medical Examiner but and physician and the prival-transit	edicai Examiner	23a. Par1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	lence of):	ar the mode of dying	g, such as cardiac	or respiratory arre	ist,		Approximate Interval Between Onset and Death
ath certi	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			1	te of delive	ry Day Year
uires that the de n signed by the a Id be detached f	by	Part II. Other significant conditions	contributing to death but not resu	ilting in the ur	derlying cause give	en in Part I.	23e. Did tob 1 ☐ Ye	~	tribute to th	e cause of death? ably 4 Unknown
	Completed						24a. Was ar autopsy perform 1 Xes 2	ed?	prior to con death?	osy findings available apletion of cause of
ilclen: Th certificate rector, pag	Be (25. Was case referred to medical examiner?					h (Check only one)		
Physicie this cert al direct	<u>۲</u>	1XXes 2 □ No 27. Manner of Death	Hospital: 1 Inpatient 2 I	ER/Outpatien 28b. Time of		4 Nursing Ho	ome 5 Reside			SCENE
To the Hospitei or Attending Physicien: within 24 hours after death. To the Funaral Diractor: After this certific completely filled in by the funeral director.	Certification:	27. Manner of Death 1 Natural 5 Pending investigation 2 Natural 5 Could not be determined 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 Nork? 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury 28b. Time of Injury 3 Nork? 1 Yes 2 No 28b. Describe how injury occurred Driver Work? 1 Yes 2 No 28b. Describe how injury occurred Driver North 1 Yes 2 No 28b. Describe how injury occurred								16+ roadwa
Hospite 24 hours Funaral stely filled	edical C	29a. Certifier (Check only one)	hysician: To the best of my know miner: On the basis of examinat and manner stated.	vledge, eath	occurred at the timestigation, in my op	e, date and place, pinion, death occur	and due to the ca	land, use(s) and ma te and place,	anner as sta and due to	ated. the cause(s)
To the within :	Mec	29b. Signature and title of certifier	Hell Oan	wa	29c. License	number ME		d. Date signe		
	te	30. Name and address of person who AROL # AU 31. Date filed (Month, Day, Year)	completed cause of death (Item	11	Print) 1 Penn St	reet, Ba	ltimore,	Maryla	and 2	1201

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Maryland		artment of I		ental Hygie	ZIIII	34764
T	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death Month	Day Year	3. Time of Death
	/Medio		Emma M. Donah 4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Death	October	4c. County of Deat	4 1:28P M
	EXAMINI	eı	Union Hospita			E1kton			Ceci1	
	Funeral Director		202-01-8971	ex 7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Yeug. 9,	9. Birt Co 1916 PA	hplace (State or Foreign untry)
	ow et		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Many e-f sh	ctor	MD Cecil	Ris	sing	Sun				1 □ Yes 🌪 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			Citizen of What Co	untry?
	eath v	eral	1881 Old Teleg	raph Rd. 12. Was Decedent Ever in U.S	3 13 3	21911	Hispanic Origin? (Spec		S.A.	rican Indian
ഗ	after d	Funeral	1 Never Married 2 Married	Armed Forces?		f Yes, specify Cub	an, Mexican, Puerto P	Rican, etc.)	Black, White	
Š	ural', c	Ď	3√ Widowed 4 □ Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:		1 □ Yes 2 □ No				hite
21215-0036	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28e-f show ta Medical Ezanii ar mual be notified at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of working	16b	. Kind of Business/	Industry
212	d withi	Julo:	Elementary/Secondary (0-12)	College (1-4or 5+)		Clerk	,		Publish:	ina
	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than Instural; or litems 23a or 28e-f show event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
Maryland	should be nd Menta marked imatic ev	၉	Charles Singl		10b Mailie	a Addrage (Street	Marion and Number or Rural	Quaden		Tin Code)
⊠ Z	ith and 27 is r	12	Arlene Donahue	** *		S 0 28				
	of Health		20a. Method of Disposition	20b. Pl	ace of Dispo	POST Rd sition (Name of matory or other pla	(6)	100	MD 2191 Location - City or	
Ē	Page ment cent: If ent: If ury or	١.	1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Whi	t.e-Li	ittrell L Home-	0ctol 2004	ber 19,	Ridley	Park, PA
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other treumatic e once.		21. Signal and Extragal Service Licen	S00	22	Name and Address	ss of Facility Gee Full	neral H	ome	
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н	Examiner	_	Sequentially list conditions, if any, leading to immediate	b. AWIL RESINA		FAILURE				3 DAYS
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o î	ate be executed hysician and the burial-transit	Еха	that initiated events resulting in death) Last	Due to (or as a consequ		ONT				1 101
8760,		dical		d						
9 X	es that the death certifica igned by the attending ph be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnar	ncy				23d. Date of deli	verv
. Box	death	lclar	in the past 12 months? 1 ☐ Yes 2 🏋 No	1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown]Ectopic pregnanc] Other (s <i>pecify</i>) _	у		Month	Day Year
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Re	The la ate ha page 2	mo/						autopsy performed 1 Yes 2 X	? death?	2 No
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ion	Attending r death. ector: Atterby the fune	atlor	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation		Injury		rk?]Yes 2 ☐ No			
Division of Vital Records,	To the Hospitel or Attending Physicien: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 Suicide 6 Could not be determined	28e. Place of injury - At hos building, etc. (Specify)	me, farm, str	eet, factory, office	2	Bf. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
	Hospitel (29a. Certifier 1 🔀 Certifying Ph	ysicien: To the best of my know	vledge, deat	n occurred at the ti	me, date and place, a	nd due to the cause	e(s) and manner as	stated.
	the Hos hin 24 h the Fur npletely	Medical		niner: On the basis of examinati and manner stated.						
	To the To the Comp	Ž	29b. Signature and title of certifier	C .		29c. Licens			Date signed (Month	
•	_		> Laule			D. D.	0058392	00	TOBER 19,	2004
	7		30. Name and address of person who D.C. SANDEEP		23a) (Type,	100 / A1	Int Daw	87. FIX.	row . mn	21921
	Sta		31. Date filed (Month, Day, Year)	3. Registrar's Signat	ure de	els)	100 - 2011	-1 ,	1 1110	- 1 1
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State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	d / Departm <i>Certific</i>	ent of Ho ate of E	ealth and N Death		giene 00	4 34765
		1. Decedent's Name (First, Middle, L	ast)				2. Dete of Dee	th	3. Time of Death
3	Physicia	B DATBATA ELIZADA	th Donnelly				October		Year 04 0900
	/Medica Examine	4a Casility Nama (If not institution a			4t	o. City, Town, or L		4c. County of	
	Examin	Lorien Nursing Ho	ome			Mt. Air	v	Carro]	1
	Funeral		Sex 7. Age (In yrs. I		nder 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
	Director	213-20-2878	1□ M 2፟ F 87	Yrs. Mont	hs Days	Hours Min.	Sept 26	1917	Maryland
	· -	Usuel Residence of Decedent			1		bept 20	,, 1517	nary rand
	ylan,	10e. Stete 10b. County	10c. City	, Town or Location					10d. Inside City Limits
	Mar Mar	Maryland Carrol		Westmin	ster				1x√2Yes 2 □ No
	r 28	Maryland Carrol		10f.	Zip Code			10g. Citizen of Wh	nat Country?
	15 will	495 Tremont Dr.	Apt. 7		21157			USA	
	filad within 72 hours after death with the Maryland Hygiene. ther than "natural", or flems 23s or 23s-1 show ent, the Medical Examiner must be notified at	495 Tremont Dr. 11. Maritel Status 1 Never Married 2 Married	12. Was Decedent Ever in U,	S. 13. Was De	ecedent of His	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		- American Indian,
0	after or the		Armed Forces? 1 ☐ Yes 2X No				Hican, etc.)		White, etc.
02	ours	35€Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 L Ye	s 2-CXNo	Specify:		Specify:	White
9	72 hg	15. Decedent's (Specify only highest g	ducation	16a. Decedent's L	Isual Occupat	tion	ring	16b. Kind of Busi	ness/industry
2	the state	(Specify only highest g	College (1-4or 5+)	life. DO NO	T use retired)	uring most of work	ing	Shives-W	/immer
7	iw bigien	12	0	Secreta	ry			Surveyin	ıg
p	offy of Hy	17. Fether's Neme (First, Middle, Las	t)			18. Mother's Nam	e (First, Middle,	Maiden Surname))
<u>a</u>	Aenta Aenta rked tlc e	Almond Brown				Theres	a Hipple	r	
Maryland 21215-0020	sho sum	19e. Informant's Name/Relationship		_		nd Number or Rui	al Route Numbe	r, City or Town, St	tate, Zip Code)
Σ	alth a	David A. Donnell	.y Son	800 Ryd	er Ct.	West	tminster	, MD 21	158
e e	other other	20a. Method of Disposition	0.0	ace of Disposition (Name of	1	Date	20c. Location - C	ity or Town, State
Ĕ	Page ento nt: 1€ ny or	1 ☐ Burial 2☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	_Hemoval from State	h Carrol:			10/15/04	Winfie	ld, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be nuttled at once.	21. Signature of Funeral Service Lice							
ä	Dapa Impo any ir		101	/10 7		Pri	tts Fune	ral Home	& Chapel, PA
		Sign Phili Fater the disease or as	80	412.1	vasning	gton ka.	westmin	ster, MD	2115/
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each line.	SCIEDILE	TICLE OF CHING.	, such as cardiac	or respiratory arr	est,	Approximate Interval Between Onset and Death
See a	Physician Medican	Immediate Cause (Final							10.
	Examiner	disease or condition resulting in death)	a. CARTIOUP	SCULAR	ים י	SPASE		<u>-</u>	10 425
155			Due to (or	es a consequence	of):				
	cate be executed physician and s the burial-transit		b						
	The law raquiras that the death certificate be executed ate has been signed by the attending physician and page 2 should be datached for usa as the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	es a consequence	of):				
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87	phys the	that initieted events resulting in death) Last	Due to (or	as e consequence	of):				
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P.O.	the a	Part II. Other significant conditions	contributing to deeth but not resu	lting in the underlyin	g cause giver	n in Part I.	23b. Did to	bacco use contr	ibute to the cause of death?
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Records,	aquii						24a. Was a perforr		24b. Were autopsy findings available prior to
ပ္ပ	The law raquir ate has been si page 2 should								completion of cause of death?
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<u>ra</u>	sian: artifica octor,	25. Was case referred to medical				26. Place of Deat	h (Check only on	e)	
2	Physician: rthis certific ral director,	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3	DOA Other	4 Nursing Ho	me 5□ Reside	ence 6 Dother	(Specify)
0	g Phy er this neral c	27. Manner of Deeth	28e. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at	28d. Describe ho	ow injury occurred	
<u>ō</u>	Attending r death. ector: After by the fune	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		M		es 2 🗆 No			
Division of Vital	tai or Attending P rs after death. ai Director: After t led in by the funera	3 Suicide 6 Could not l		ne, farm, street, fac	tory, office		28f. Location (St City or Town	reet and Number	or Rural Route Number,
	od in Dir	4 Tronnoide	Dullaring, etc. (Specify)				Only of Your	, 51616/	
	To the Hespital or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	29a. Certifier 1 Certifying P	ysician: To the best of my know	ledge, deeth occurr	ed at the time	, date end place,	and due to the ca	ause(s) and mann	er as stated.
	n 24 hou n 24 hou e Funer pletely fil	(Check only 2 Medical Exa	niner: On the basis of exemination and manner stated.	on encor investigat	ion, in my opir	nion, death occurr	ed at the time, d	ate and place, and	due to the cause(s)
	within To the comp	29b. Signature and title of certifier			29c. License	number	2	9d. Date signed (i	Month, Day, Year)
			M		D-3	1912	1	0/15/0)4
	W. Xs	30. Name end eddress of person who	completed cause of death (Item	23a) (Type Print)	300 8 1 7 5 1 1 5		2.5	1-0.5	
	1,	JULIO MELOCAL	ND /1564 080	SSUMTOU	PI'	ue fre	DERIL	k mo	21702
	State	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	are			V	•	
	Registra	nct 1	8 2004 Heren	. K 1	ments 1				

		-	For State Registrar	State of Maryland	-	artment of H tificate of		nd Mental Hy	giene 200	4 34766
	5 1	_	1. Decedent's Name (First, Middle, Lasi	"				2. Date of De Month		3. Time of Death
	Physicia /Medic	al	Vera Lee Dull					Octobe	r 14, 2004 4c. County of 6	
	Examin	φ.	4a. Facility Name (If not institution, give			4b. City, Town, o		Death	Anne An	
	Funeral		Anne Arundel Medic 5. Social Security Number 6. Se	7. Age (In yrs. I	ast birthday)	If Under 1 Year		Hrs. 8. Date of Bi		Birthplace (State or Foreign Country)
	Director		212-24-9106	□ M 2 XX F 77	Yrs.	Months Days	Hours	July 9		aryland
	and w	-	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho	to	Maryland Anne Arun	del Anna	apolis					1 ☐ Yes 2XXNo
	h the	Funeral Directo	10e. Street and Number	.ucı	porre	10f. Zip Code			10g. Citizen of Wha	it Country?
	ath wil	lai	1857 Baltimore Ann			21401			United Sta	
	er de:	nue	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in U.Armed Forces?1 ☐ Yes 2 No	S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origi an, Mexican,	n? (Specify Yes or Ne Puerto Rican, etc.)	Black, \	American Indian, White, etc.
38	urs aft	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2/2 No	Specify:		Specify:	White
5-0036	filed within 72 hours after death with the Maryland Hygiene. Viter then "naturel", or Items 23e or 28e-f show ont. The Macifical Examiner must be mailfied at	Completed by	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occup	during most of	of working	16b. Kind of Busin	ess/Industry
2121	Athin ne.	mpje	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retire	id)		27	
2	filed w Hygiel ther t	e Co	17. Father's Name (First, Middle, Last)	2		Nurse	18. Mother	s Name (First, Middle	Nursing a, Maiden Sumame)	
_	0 = 0 \$	m	Vernon Ely				Corrir	e UNKNOW	N	
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Items 23e or 28e-f show eumatic event. It Marical Examinet must be multimed at		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Number	or Rural Route Numb	per, City or Town, Sta	ite, Zip Code)
Σ	permit. Pages 1 and 2 should be Department of Health and Mente Importent: If item 27 is marked any injury or other treumatic et <u>pnce</u> .		Franklin Dull / Hu	sband	1857	Baltimore	Annap	polie Blvd Date	Annapoli	y or Town, State
altimore,	ges 1 t of H if iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removal from State	emetery, crei	matory or other pla	ice)			
<u>=</u>	it. Pa intmen intent: njury		* 4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen			e Cremato 2. Name and Addre				e, Maryland Funeral Home
Ba	permi Depa Impo any is		Michal!	Ivam				ucester S	-	lis, MD 21401
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the death	h. Do not ent	ter the mode of dyi	ing, such as c	ardiac or respiratory a	arrest,	Approximate Interval Between
)	Physician		Immediate Cause (Final disease or condition	a	LUM	g can	cer			Onset and Death 2 YVS.
	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	J				
		E C	Sequentially list conditions,	b. Due to (or as a conseq	uenes ut):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c						
o,	ate be executed hysician and the burial-transit	Еха	resulting in death) Last	Due to (or as a conseq	uence of):					
	cate be executed physician and the burial-transit	dical		. d						
9	eath certifica attending pt for use as t	/Med	IF FEMALE:	23c. If yes, outcome of pregna	ancy				23d. Date of	f delivery
Вох	death a atten d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\sum \) Yes 2 \(\sum \) No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	y 		Month	
<u>о</u> .	ut the c by the tacher	hys	9 Unknown	9∐Unknown						41.00
Records, F	The law requires that the death certific ate has been signed by the attending prage 2 should be detached for use as	þ	Part II. Other significant conditions c	ontributing to death but not res	ulting in the u	inderlying cause gi	ven in Part I.			ite to the cause of death? ☐ Probably 4 ☐Unknown
900	e law requir has been si ge 2 should I	Completed						24a. Wa	opsy prio	re autopsy findings available r to completion of cause of
œ —	The ate his	Com						perf 1 Yes	ormed? dea 2 No 1 □	th? Yes 2□ No
/ita	icien: Sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:		0:	hor	of Death (Check only		
of Vital	Physicien: r this certificaral director,	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpaties 28b. Time of	nt 3 DOA	4 Nurs	sing Home 5 - Res 28d. Describe	how injury occurred	(Specify)
o	Attending r death. ector: After by the fune	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yeer)	Injury		ork?]Yes 2.∐N	o		
Division	l or Atter after dea Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif		reet, factory, office			(Street and Number own, State)	or Rural Route Number,
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Ph (Check only one) 1 Medical Exer	ysicien: To the best of my kno niner: On the basis of examina and manner stated.	owledge, deat ation and/or in	th occurred at the to estigation, in my	time, date and opinion, death	place, and due to the n occurred at the time	cause(s) and mann , date and place, and	er as stated. I due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	~ 0 -		29c. Licen	se number		29d. Date signed (Month, Day, Year)
	, . , . .		+ Felow	uchs 40			14838		(01151	2004
			30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	Print) Print)	estga	te Rd.	Auncepoli	s, Wa,
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Praistrar's Signa	ature	Speeds)				

		4	For State Registrar	State of Ma	aryland		artment rtificate			and M		giene (04	34767
7		13	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dea	Day	Year ,	3. Time of Death
es seri	Physici /Medic	_	Alan LeRoy Daugh	narthy, Jr	•						Octobe	59	2004	4:58 pm
	Examir	-	4a. Facility Name (If not institution, give	street and number)	,		4b. City,	Town, or	Location o	of Death		4c. Ćou	inty of Death	
			Maryland Gener	al Hospi-	a	6 to laste of - 13	16 Under	-imo	If Under	ity	O Data of Bird		O. Dist	La Contraction
	Funeral Director		5. Social Security Number 6. S 1 212-66-9692	ex StM 2□F	e (in yrs. ii 45	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da July 17	y, Year)	Coui	place (State or Foreign ntry) yland
		ŀ	Usual Residence of Decedent		- 4 -3		l				July 17	, 133.	7 1101	yiana
	nylan nhow	_	10a. State 10b. County		10c. City	, Town or Lo	ocation							10d. Inside City Limits
	with the Maryland a or 28a-f show be collified at	by Funeral Director	Maryland Baltime	ore	Ва	altimo								1 Yes 2 No
	with th	D I	10e. Street and Number				10f. Zip					-	of What Coul	ntry?
	eath w	erai	1046 Old North Poi	nt Road	Ever in U.S	S 13		224	snanic Orio	nin? (Sne	cify Yes or No	US	SA Race - Americ	can Indian.
	fter dea	F	1 ★ Never Married 2 Married	Armed Forces?			If Yes, spec	ify Cuba	n, Mexican	, Puerto I	Rican, etc.)		Black, White,	etc.
21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f show Jisal Exama or must be mailfied a	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2	2⊠ No	Specify:			Spe	city: Wh:	ite
5-0	72 ho natur	Completed	15. Decedent's Ed (Specify only highest gra	ducation ide completed)		(Give	dent's Usua kind of wor	k done d	lurina most	t of workin	ng	16b. Kind o	f Business/In	dustry
121	vithin ne. han	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		DO NOT us						<i>t</i> –	
	Hygie Hygie ther t		12 17. Father's Name (First, Middle, Last)			Nor	ne (Di	_sab]		r's Name	(First, Middle,	Maiden Sun		
Maryland	nit. Pages 1 and 2 should be filed within 72 hours after death w admental Hygiene. ortannel of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural; or Items 23e injury profiter traumatic event, Ite Mudical Examine manal injury profiter.	To Be	Alan LeRoy Daugh					İ			oeth An			
ary.	shoul nd Me mark	Ĕ	19a. Informant's Name/Relationship (19b. Mailie	ng Address	(Street a			Route Numbe			Code)
ž	alth a		Mary Beth Rummel/	Sister		250 M	Manor	Circ	cle, '	Takor	na Park	.MD 20	912	
ore,	of He		20a. Method of Disposition 1 Burial 2 Toremation 3	Demousl from State		ace of Dispo) (er 15,	20c. Location	on - City or To	own, State
Ë	Pages nent of l		'4 □Donation 5 □Other (Specif				opoli atory			200	'	Alexa	ndria.	Virginia
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury prother tra any injury prother tra		21. Signature of Funeral Service Licer	100		F1	2. Name and	Addres	Coll	ins 1	Tuneral	Home	Inc.	
ω,	20E # 3		1 Gm b. D	cener		50	o Uni	vers	sity !	Blvd,	W, Si	lver S	pring,	
25/1			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death ne.	. Do not ent	er the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
1.5	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Sep-	tic	Sho	cK_							3 days
	Examiner		1	Due to (or as	a consequ	ience of):		Car	Hior					2-1
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a oonsequ	ience of):	1-1	1700	1101	1				paays
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C										
o,	be execut sicien and burial-tran	Exa	resulting in death) Last	Due to (or as	a consequ	ience of):								
8760,	P	Physician/Medical	•	d										
9	leath certifica attending ph I for use as th	Mec	IF FEMALE:	23c. If yes, outcome										
Вох	death certific e attending p id for use as i	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3[Ectopic pre					23d.	Date of delive Month	ery Day Year
P.O.	the d	ysic	1 Yes 2 No	9□ Unknown	tane or de	5au 3 C	_ Other (spe	-ciiy)						
	res that the signed by be detact	y Ph	Part II. Other significant conditions of	ontributing to death b	ut not resu	ılting in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco use c	ontribute to ti	ne cause of death?
rds	requires that een signed b nould be deta	ed by									1 🗆 Y	res 2 N	3 Prob	pably 4 □Unknown
00	S C <	piet									24a. Was		b. Were auto	psy findings available mpletion of cause of
R	iician: The lav certificate has rector, page 2	Completed							_			rmed?	death?	
ita	sian; artifica ictor,	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only o			
of ∨	Physician: this certific ral director,	၉	1 ☐ Yes 2 ◯ No	Hospital: 1 Inpatie		ER/Outpatier			4 🗆 Nu		ne 5 Resid			y)
n c	ding P	lon:	27. Manner of Death t □XNatural 5 □ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury	f 2	Bc. Injury Work	at ? ∕es 2.∐1		8d. Describe h	now injury oc	curred	
Division of Vital Records,	Attending r death. ector: Afte by the fune	Certification:	2 Accident investigatio 3 Suicide 6 Could not b	e Ope Place of lei	urv - At ho	me farm sti			95 Z 🗀 I		8f. Location (S	Street and Nu	imber or Rura	al Route Number.
Di∨	after Direct	ertif	4 Homicide determined	building, et	c. (Specify	")	oot, ractory	, 011100			City or Tox			in realistic realistics,
	spita hours ineral y fillec			ysician: To the best										
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examone)	niner: On the basis o and manner st	f examinat ated.	ion and/or in	vestigation,	in my op	inion, deal	th occurre	ed at the time,	date and plac	ce, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	0.	/				number				ned (Month,	
	0		14/1	4	m. E	١.	7	395	36			10	4-0	7
	7		30. Name and address of person who	completed cause of d	0		Print)		C/0 1	ma-	uland	1.0.00	cal 11	4 Ospital
	Sta	to	31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ture	IND.		, , ,	11001	ylaro	vene	ial H	uspital
	Regist	-	OCT 18 20		Carried Control	19	200	Ma						

		1 - For State Registrar	State of	Maryland / Depa <i>Ce</i>	artment of F rtificate of			ene 2004	34768
Physic		1. Decedent's Name (First, Middle, Michael D	ast) iBe11a				2. Date of Death Month October	Day Year	3. Time of Death
/Medi Exami		4a. Facility Name (If not institution, g	ive street and num	nber)	4b. City, Town, o	r Location of Death		4c. County of Dea	th
Funeral Director		Suburban Hospi 5. Social Security Number 6 578-10-3608		7. Age (In yrs. last birthday) 85 ^{Yrs.}	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Nov. 24,	Year) 9. Bir	tholace (State or Foreign buntry)
Maryland	tor	Usual Residence of Decedent	merv	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the 3a or 28a	i Direc	10e. Street and Number		Rensing	10f. Zip Code	20895	10	og. Citizen of What Co	
72 hours after death with the Maryland natural', or Items 23a or 28a-f show iteal Exercities - wat be notified at	by Funeral Director	4216 Matthews L 11. Marital Status 1 Never Married 2 Married 3 Midowed 4 Divorced	12. Was Dece Armed For	2 No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	tispanic Origin? (Sc	pecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify:	erican Indian, de, etc.
within 72 hours aff ene. than "natural", or he Medical Expiri	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	sing 1	16b. Kind of Business	
nd 2 should be filled wir Ith and Mental Hygien 27 Is marked other th traumatic event, Ing	To Be Co	17. Father's Name (First, Middle, La	st) e11a	Idii	.01	18. Mother's Nam	le (First, Middle, M	faiden Surname)	
		19a. Informant's Name/Relationship Michael S. DiBe 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3	11a	Son 10829	Greenvie	ew Way	Columbia	City or Town, State, a Maryland	21044
permit. Pages 1 ar Department of Hez Important: If item any injury or othe		* 4 □ Donation 5 ☒ Other (Spe 21. Signature of Funeral Service Li	city)Entombr	nent Gate Of C	Cemetery 2. Name and Addre cancis J.	ss of Facility Collins	Funeral I	Silver Spr Home, Inc. ver Spring	ing Marylan
Physician /Medical		23a. Park. Enter the disease, of or shock, or heartfailure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on e.	aused the death. Do not enach line. monia or as a consequence of):	ter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death 7 days
icate be executed physician and in the burial-transit	dicai Examiner	Sequentially list conditions, any lasting to make a cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	or as a consequence of):					
ath certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	ant at time of death 5	□Ectopic pregnancy	<i>y</i>		23d. Date of de Month	livery Day Year
hat hd b	by	Part II. Other significant condition	s contributing to de	eath but not resulting in the t	ınderlying cause gıv	ren in Part I.		acco use contribute to	
The law rate has be page 2 st	Completed						24a. Was am autopsy perform 1 Tes 2	prior to death?	utopsy findings available completion of cause of
Attending Physician: The death. sector: After this certificate by the funeral director, page	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 No New Yes 1 Pending investiga	28a. Date of	npatient 2 ER/Outpatie of Injury h, Day Year) 28b. Time of Injury	of 28c. Injur Wor	er: 4 Nursing H	th (Check only one ome 5 - Resider 28d. Describe how	nce 6 □Other (Spe	cify)
To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	200. Flace	of Injury - At home, farm, st ng, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or R. , State)	ural Route Number,
the Hospi in 24 hour the Funer ppletely fill	Medical	(Check only 2 Medical Ex	aminer: On the ba	best of my knowledge, dea asis of examination and/or in her stated.	nvestigation, in my o	ppinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	2	29b. Signature and title of certifier	ns	no	29c. Licens	37891		ctober 14,	
10+1		30. Name and address of person w	.D. 121	Congressiona	Print)		ville, Ma		0852
St Regis	ate trar	31. Date filed (Month, Day, Year) OCT 18		egistrar's Signature	South				

		1 - For State Registrar	State o	of Marylan	d / Depa <i>Cei</i>	artment of H rtificate of L	lealth and Death	Mental Hyg	iene 2004	34769
		1. Decedent's Name (First, Middle,	Last)					2. Date of Deat Month	h Day Yeer	3. Time of Death
Physic /Med		ANNA AUGUSTA	EVANS					10	17 2004	
Exami		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, or	Location of Dear	h	4c. County of Dea	ath
		Manokin Manor Nu				Princes			Somerse	
Funera	1	5. Social Security Number	6. Sex 1 □ M 2 1 F	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hrs Hours Min	(Month, Day,	Year) 9. Bi	rthplace (State or Foreign country)
Director		714-18-2294	10.00	10)5 Yrs.			08/15/18	399 Pee	nsylvania
and		Usual Residence of Decedent 10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside City Limits
Marylan f show	ō		.1	Dead		Anno				1 TYYes 2 □ No
the 1	Director	MD Somers 10e. Street and Number	ec	PI	incess	10f. Zip Code		10	og. Citizen of What C	Country?
a or		30402 Pine Stre	ot			21853			USA	
death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. \	Was Decedent of Hi	ispanic Origin? (S	Specify Yes or No-	14. Race - Am	
affer of the second	F	1 Never Married 2 Marrie	Amed Fe	2 (Z)No	1	f Yes, specify Cuba		to Hican, etc.)	Black, Wh	ite, etc.
er, c	þ	3 ☐ Widowed 4 ☼ Divorced	If Yes, G Year or D	ve Dates:		1 ☐ Yes 2 🖾 No	Specify:		Specify: W	hite
72 hc	Completed	15. Decedent' (Specify only highest			16a. Deced	dent's Usual Occupa	ation during most of wo	rkina	16b. Kind of Business	s/Industry
ithin ithin	n de	Elementary/Secondary (0-12)		1-4or 5+)	life. I	DO NOT use retired)			
ed w ygier t,	Š	12			Offic	ce Manage			Newspape	er
In y latter 2.12.15.15.15.25.25.25.25.25.25.25.25.25.25.25.25.25	Be	17. Father's Name (First, Middle, L	.ast)					me (First, Middle, A		
y ould ould Men Merke	ို		ward		T W. Seed			a Schill:		
2 sh 1 and 1 s m		19a. Informant's Name/Relationsh		`		-			City or Town, State, MD 21853	
and lealth			daughter						20c. Location - City o	
ges 1		20a. Method of Disposition 1 № Burial 2 □ Cremation	3 Removal from	State		sition (Name of natory or other plac	\$		er care	
t. Pa tmen tant: njury		'4 □Donation 5 □ Other (Sp		Blai		ial Park		1/2004 B	ellwood, I	PA
permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other treumetic evenue.	X	21. Signature of Fureral Service L	Delin		Ho	Name and Address Olloway M 03 Linden	elson Fu	neral Hor Pocomoke (me, P.A. City, MD 2	21851
		23a. Part1. Enter the disease, or a shock, or heart failure. List of	complications that	caused the death			•			Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	,			Asivi	n			Onset and Death
/Medical	1	resulting in death)	a Due to	(or as a conseq	uence of):	17001	/			
Examiner	1	Sequentially list conditions,	b							
p =	ne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence	uence of):					
ocuter nd trans	Examiner	that initiated events	c							
e exe	Ě	resulting in death) Last	Due to	(or as a consequ	uence of):					
ate b hysic the b	dlcal	Л	d							
ertific ling p	Me	IF FEMALE:	00- 16							<u> </u>
ath co	lan/	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregna birth 2 Feta	Ideath 3	Ectopic pregnancy			23d. Date of de Month	elivery Day Year
the a	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Preg 9☐Unkr	nant at time of de nown	eath 5∟	Other (specify)				,
hat the d by detac		Part II. Other significant condition	ns contributing to c	leath but not res	ulting in the u	nderlying cause give	en in Part I	23e. Did tob	acco use contribute t	o the cause of death?
ries trassigne	by						.,,,,,,	1 □ Ye		robably 4 Unknown
requ	Completed							24. 146	241 141	de de la companya de la companya de la companya de la companya de la companya de la companya de la companya de
e law	ldπ							24a. Was ar autops perform	prior to	utopsy findings available completion of cause of
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icien icien Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:			Othe	00	ath (Check only one		
Phys this	2	1 ☐ Yes 2 ☐ No 27. Manyrer of Death	1 1 1		28b. Time of	IL 3 DOA	4 🗀 Nursing i	lome 5 ☐ Reside	nce 6 Other (Spe	ecify)
fing After funer	lo	1 Natural 5 ☐ Pending		of Injury oth, Day Year)	Injury	Work	Yes 2 □No	20d. Doscribo no	w injury occurred	
ttend death stor:	icat	2 Accident investig	ot be	e of Injuny - At ho	ome farm etr	eet, factory, office		28f Location (Str	eet and Number or R	Jural Route Number
or A after a Direction by	Certification:	4 Homicide determi	ned build	ling, etc. (Specify	y)	eet, factory, office		City or Town	State)	urai rioute rumoer,
spital ours ours ierel filled		29a. Certifier 1 Certifying	Physician: To th	e best of my kno	wledge death	n occurred at the tim	ne, date and place	a, and due to the ca	use(s) and manner a	s stated
24 hos Fun	Medical	(Check only 2 Medical E	Examiner: On the b	pasis of examina nner stated.	tion and/or in	vestigation, in my op	oinion, death occ	urred at the time, da	te and place, and du	e to the cause(s)
To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	₹ E	29b. Signature and title of certifier				29c. License	number	29	d. Date signed (Mon	th, Day, Year)
⊢ ≯ ⊢ 0	and the second	Inde water	DR-4SHA	Action is a f		٥٥	57359		October 19	15 200U
		30. Name and address of person v					-/			
							Ry MOD	1804		
s	tate	31. Date filed (Month, Day, Year)	32.1	Registrar's Signa	ture		, ,	-		
Regis		net 2	0 2004	Regent	B. 16	sarisau Saulis				
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			_ For	• -		i / Depa	artment of H	ealth and	Mental Hyg		
			State Registrar			Ce	rtificate of L	Death	F	Reg. N& 0 0 L	34770
			1. Decedent's Name (First, Middle, Last,)					2. Date of Dea Month	ath Day Yea	3. Time of Death
	Physici /Medic		Josephine C		Eyle	er			Octobe		
	Examin		4a. Facility Name (If not institution, give	street and number)	i		4b. City, Town, or	Location of Deat	h	4c. County of De	
			Frederick Mem	orial Ho	spit	al	Frede:	rick		Freder	ick
	Funeral		Social Security Number 6. Se		e (In yrs. Ia	• • • • • • • • • • • • • • • • • • • •	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			Birthplece (State or Foreign Country) .rginia
	Director		228-26-6245]M 2∏F	80	Yrs.	World Days	TIOUTS INTE	March	1924 Vi	rginia
	2 >		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	nation				10d. Inside City Limits
	anyla ehov	<u>_</u>	Maryland Frederic	1.							1 ☐ Yes 2 1 No
	death with the Maryland ms 23a or 28a-f ehow Frivat Le natified at	Director	<u> </u>	K.	Inu	rmont					
	vith ti	吉	10e. Street and Number				10f. Zip Code			10g. Citizen of What	Country?
	ath \	Funeral	14731 Sabillasvill				2178			U\$A.	
		une	11. Marital Status	12. Was Decedent Armed Forces?		. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puer	pecify Yes or No- o Rican, etc.)	Black, W	merican Indian, hite, etc.
5	ours after death with the Marylan ral', or Itams 23a or 28a-f ehow Exemirer must be notified at	by F	1 Never Married 2 Married 3	1 ☐ Yes 2 🔼 If Yes, Give Year or Dates:	NO		1 ☐ Yes 2 🖾 No	Specify:		Specify:	White
5-003	"natural, or Ita	edt	15. Decedent's Edu		1	16a Dece	dent's Usual Occupa	etion		16b. Kind of Busine	es/Industry
Ö	in 72 ho "natur	Completed	(Specify only highest grad	e completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	luring most of wo	rking	TOD. Talla of Dustile.	33 modali y
7	within ene.	E C	Elementary/Secondary (0-12)	College (1-4or 5	5+)		l Service	,		County (Government
7	Hygi other	ပိ	17. Father's Name (First, Middle, Last)					18. Mother's Nar	ne (First, Middle,	Maiden Sumame)	
a	o g a b	To Be	John William Baire	1				Hatti	e K	irby	
<u>-</u>	s 1 and 2 should be I Health and Menta Item 27 Is marked other traumatic e	1	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailir	ng Address (Street a	and Number or Ru	ıral Route Numbe	r, City or Town, State	a, Zip Code)
<u> </u>	and 2 sauth ar n 27 is ner trau		Sharon E. Price/Da	,			Box 115		Ridge, M	-	
a)	s 1 and if Health item 27 other tr		20a. Method of Disposition	igncer	20b. Pla	ace of Dispo	sition (Name of		Date Pate	20c. Location - City	or Town, State
Saitimor	Pages nent of int: If it		1X Burial 2 ☐ Cremation 3 ☐ F	Removal from State			matory`or other place ge Cemete:	1	1/2004	Thurmont,	MD
₹.	rtme rtan riun		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens		Dia	-		1 -		uneral Hon	
g	permit. Pages Department of Important: If it any injury or o		21. Signature of Furnaral Service Licens	2				The second secon		nt, MD 217	SUPPLY COLUMN TO THE PROPERTY OF THE PROPERTY
			220 Party Street the diseases women	ications that caused	t the death						Approximate
			ck, okhlart failure. List	e cause on each li	ne.	Do not ent	er the mode or dying	g, such as cardia	or respiratory ari	rest,	Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	SEPSI	S						3DAYS
	/Medical Examiner		resulting in death)	Due to (or as				,			WWW.CEA-F
	LAMITHE	L	Sequentially list conditions,				HOCYTIC	LEUKE	NA		4 Maria
	sit ad	Examiner	Sequentially list conditions, tary loading to the cause. Enter Underlying Cause (Disease or injury	Due to (or as							2:100
	and trans	Cam	that initiated events resulting in death) Last			OPA7	99				SYRS
ρΩ,	e be executed /sician and e burial-transit		Todding in dodiny cast	Due to (or as	a conseque	ence or):					
-	ate t hysic	dical		d				-			
200	ing pe as	Med	IF FEMALE:		•						
Z D D	death certificate I e attending physi id for use as the b	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome! 1 Live birth	2 Fetal o	déath 3□	Ectopic pregnancy			23d. Date of d Month	delivery Day Year
	0 0 0	Physician/Medi	1 Pes 2 No	4□Pregnant at 9□Unknown	time of dea	ath 5□	Other (specify)			19101101	Day / Gui
ī.	± ≥ o	Phy						8.00	00 8:44		
ທົ		by	Part II. Other significant conditions co		out not result	-	nderlying cause give	en in Part I.			to the cause of death?
ecoras	requires seen sign hould be	ted	CORDINATOR MI	10-7	Noch	W.E.	_		1 L Y	es 2 No 3	Probably 4 🗷 Unknown
ပ္သ	a ≅ ⊘	Completed							24a. Was a		autopsy findings available o completion of cause of
r	o <u>-</u> e	E O							perfor	med? death	? es 2□ No
Z Z	i cia n: Th certificate rector, pag	O	25. Was case referred to medical					26. Place of Dea	th (Check only or		
	Physician: r this certific ral director,	To B	examiner?	Hospital: 1 Hinpatie	ent 2 🗆 E	R/Outpatier	nt 3 DOA Othe	er: 4 🗌 Nursing H	lome 5 Resid	ence 6 Other (S	pecify)
10	Da 0 0		27. Manner of Death	28a. Date of Inju	ry Year) 2	28b. Time o				ow injury occurred	
UNISION	Attending I r death. ector: After by the funer	atlo	1 Katural 5 Pending 2 Accident investigation	(1101111), 24	, , , , , ,	Mijary		res 2 □ No			
<u>8</u>	Atte	ific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inj	ury - At hon	ne, farm, str	eet, factory, office		28f. Location (S. City or Town	treet and Number or	Rural Route Number,
5	s after	Certification;	T LI TIOTHOGO	building, or	c. (Opecity)				Only or Tom	n, clare)	
	hours inera y fille	al (29a. Certifier 1 Certifying Phy	sician: To the best	of my know	riedge, deati	n occurred at the tim	e, date and place	, and due to the c	ause(s) and manner	as stated.
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical	(Check only 2 Medical Exami	ner: On the basis of and manner sta	r examinatio ated.	un and/or in	vestigation, in my op	nnion, death occu	rred at the time, d	late and place, and d	ue to the cause(s)
	Within To the County	ž	29b. Signature and title of certifier	^ ^ ~			29c. License			29d. Date signed (Mo	nth, Day, Year)
1			VIII	MD			DOE	56316	t	10/18/2	004
	5.9		3 Nam and ad ress of person who co	ompleted cause of d	leath Item.	23a) (T pe.	Prin	emp		- T-1000	
	7		DINDU GEORGE,	46B THOM	MAS JO	DHINSON	V DRIVE,	TKEDEK	LA IND Z	1102	
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signatu		, ,	,			
	Registr		OOT 9	2004	Lener	-	& So	ach			
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien® O O I

			1 - For State Registrar	State of Marylan	Cei	rtificate of	Death		Reg. No.		34771
	Physici	30	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Ernest	Dale	Foo	gle		10	17	04	3:00 A ^M
1	Examin	er	4a. Facility Name (If not institution, give s				or Location of Deat	h	4c.	County of Deeth	
		4	7710 Swan Terra		lant hinthday	Land		O Data of Bio	46	P.G.	(2)
	Funeral Director		249-70-4570	7. Age (In yrs,	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	iy, Year)	43 So.	lace (State or Foreign try) Carolina
	pue *		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation				11	0d. Inside City Limits
	n 72 hours after death with the Maryland "naturel", or Items 23a or 28a-f show jedical Examine mast be modified at	ctor	MD P.G.	i		dover					1 □XYes 2 □ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Coun	try?
	23a		7710 Swan Terr	ace		207	85			U.S.	
	tems	Funeral		2. Was Decedent Ever in U Armed Forces?	.S. 13. 1	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	pecify Yes or No o Rican, etc.))-	 Race - Americ Black, White, 	an Indian, etc.
0030	hours after turel', or Ite	by	1 ☐ Never Married 2 ☐ Marned 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 4-5-4 1 X Yes 2 No If Yes, Give Year or Dates: 4-4	71	1 □ Yes 2 No	Specify:			Specify: Bla	ck
	72 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	pation	rkina	16b. Kii	nd of Business/Inc	dustry
-C1212	within 72 ene. than "na	nple	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wo	ning .	U	S. POst	al Syc
	filed w Hygien other th	S	12		Ge	eneral (ar bvc.
/land	od la b o	Be	17. Father's Name (First, Middle, Last)					ne <i>(First, Middl</i> e e Marti		Sumame)	
_	nouid J Men narke	မ	Paul Fogle Sr.	n Orient	101 11-75					- 0	
Mag	12 st h and 7 is n trsun		19a. Informant's Name/Relationship (Typ			-	and Number or Ri				
o,	s 1 and 2 should Health and Mer tem 27 is marke other traumatic		Hilda B. Fogle- 20a. Method of Disposition		Place of Dispo	SWan 'I sition (Name of matory or other pla	Terrace,	Lando	ver	MD 20 cation - City or To	78 <u>5</u> wn. State
Бащтог	Page: nent of ant: If i		1 Burial 2 □ Cremation 3 □ Re 1 □ Donation 5 □ Other (Specify)	emoval from State Ha	rmony	Memori	lal Pari		Lar	ndover,	MD
Dail	permit. Departr Imports any inju		21. Signature of Funeral Service License	S. Colli	22 8 D / H	Name and Address Nome 250	ess of Facility Bo 14 28th	nnette	& <i>I</i>	Assoc.	Funeral
	*		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that ceused the deat	h. Do not ent	er the mode of dyi	ng, such as cardia	or respiratory a	rrest,	WDC Z	Approximate Interval Between
į.	Physician Physician		Immediate Cause (Final disease or condition	OROPH,	ARYN	CEAL	CAI	NOFR			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq		00010		occ.	-f		
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	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last								
Š,	ificate be executed g physician and as the burial-transit		Togaling in addity cast	Due to (or as a conseq	uence or):						
09/89	physic	edical	d								
			IF FEMALE:	3c. II yes, outcome of pregna	ancy					and Date of delice	
ô	death cert e attendin d for use	Physician/M	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3	Ectopic pregnanc Other (specify)	у		2	3d. Date of delive Month	ry Day Year
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J.	that led by deta		Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to th	e cause of death?
cords	iaw requires that as been signed b 2 should be deta	d by						10	Yes 2	No 3 Proba	ably 4 Unknown
S	w req	lete						24a. Was	an	24b. Were autor	osy findings available
Ţ	0 4	Completed							rmed?	prior to con death? 1 \(\sum \text{Yes}	npletion of cause of
VITAI	ician: The certificate ector, pag	O	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		12,163	20,140
	9 0	0 8	examiner? 1 ☐ Yes 2 🏋 No	ospital: 1 Inpatient 2	ER/Outpatien	nt 3□ DOA Ott	100			Other (Specify)
0	ding Phy h. After thi funeral o	Ë.	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Inju	ry at	28d. Describe	how injury	occurred	
0	Attending ir death. ector: After by the fune	atlc	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	,,	,,		Yes 2 □ No				
DIVISION	를 를 들	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str y)	eet, factory, office		281. Location (City or To		d Number or Rural	Route Number,
	e Hospitel 24 hours a Eunerei I	Medical C	29a. Certifier (Check only one)	ician: To the best of my kno er: On the basis of examina and manner stated.	wledge, death	n occurred at the tr vestigation, in my	me, date and place opinion, death occu	e, and due to the erred at the time,	cause(s) date and	and manner as sta place, and due to	ated. the cause(s)
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	⊢ 3 ⊢ ŏ		1 Malark	10A			noco	000		11/2-1	24/
n	tol	1	30. Name and address of person who	mpleted cause of death (Iten	23a) (Type	Print)		30	1	7501	7
1	(4)	a	Mahrith H	USSOUN	MT	1221	Mercan	tile L	n.L	Aroso.W	0 201774
0	Sta	te	31. Date liled (Month, Day, Year)	32 Registrar's Signa	ature	1	110000	0000	× 1 × ·	71	
	Registr		207 2 8 2004	Z.		10 a					

hysicia	ın	Decedent's Name (First, Paul	Middle, Lasi E.	Ford						2. Date of De Month Octobe		6-04 _{ear} 2004	3. Time of De 9:00
/Medica xamine		4a. Facility Name (If not ins	itution, give	street and num	ber)		4b. City, Town	, or Location	of Death		4c. Co	ounty of Death	h
		8813 Sterlin	g Str	eet			Land	over			Pri	nce Ge	orge's
neral ector		5. Social Security Number 216–86–9140	6. Se	ex 7 MSM 2□F	7. Age (In yrs. 38	. last birthday) Yrs.	If Under 1 Yes Months Day		24 Hrs. Min.	8. Date of Bird (Month, Da June 6	th y, Year) 1966	Cot	nplace (State or Fountry) 7 land
	-	Usual Residence of Deceder 10a. State 10b. C			10c Ci	ity. Town or Lo	ocation					1	10d. Inside City L
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TUMB	era	8813 Sterling	3 Stre	12. Was Deced	dent Ever in U	J.S. 13.	Was Decedent of		iain? (Sp	ecify Yes or No		S.A. Race - Amer	rican Indian,
	딢	1 Never Married 2	Married	Armed Ford	ces?		Was Decedent of If Yes, specify C		n, Puerto	Rican, etc.)		Black, White	
DESE	þ	3 ☐ Widowed 4 ☐ Div		If Yes, Give Year or Dat	9		1 ☐ Yes 2 🙀 N	o Specify	:		St	oecify:	B1ack
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Med	- ple	Elementary/Secondary (0		de completed) College (1-	4or 5+)	life.	DO NOT use ret	red)	SI OF WORK	my			
2	Son -	12th				Me	echanic					Privat	:e
5 C	Be (17. Father's Name (First, M						18. Moth	er's Nam	e (First, Middle,	Maiden Su	imame)	
atic	2	Tommy Lee	Jone	es						a M. Fo			
is marked or eumatic eve		19a. Informant's Name/Rel	ationship (7	Type, Print)			ng Address (Stre						
other tre		Hemroetta M	. Jone	es/Mothe			Sterlin	g Stre					
or other		20a. Method of Disposition 1 Burial 2 □ Crem	ation 3 □	Removal from S		Place of Dispo cemetery, crei	osition (Name of matory or other p	lace)		Date	20c. Loca	tion - City or 1	Fown, State
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Imponent: If Ite any injury or ot once.		21. Signature of Funeral S	rvice Licen	see		22	2. Name and Add	tress of Facil	ity J.	B. Jen	kins	Funera	1 Home
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= 6 0		23a. Fanti. Enlar ha risea shock, or heart failure	se, or comp	plications that ca	used the dea	74	474 Land					ryland	Approximate Interval Between
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	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, La PATRICIA 4a. Facility Name (If not institution, give	ANN	Ĩ-	LOYD	ocation of Deat	2. Date of Dea Month	Day Year Ac. County of Dea	3. Time of Death 302 A M
	Funeral Director		005-46-4165	SES HOSPIT 7. Age (In y/s 61	A L i. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.			thplace (State or Foreign ountry)
	ne Maryland 8a-f chow	Director	Usual Residence of Decedent 10a. State 10b. County D • C •	10c. C	ity, Town or L Washi	ngton			40.00	10d. Inside City Limits 1⊠ Yes 2 □ No
036	be filed within 72 hours after death with the Maryland nat Hygiene. do other then "natural", or items 23a or 28a-f show event, I'ra Medical Exariline Frant Le mullified at	by Funeral	10e. Street and Number 5330 E St . SE #1 11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced	0 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 (%) No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (S , Mexican, Puer	Specify Yes or No-	Black, Whi	erican Indian,
121215-0036	within ene. then	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+) 4 yrs.	(Give	dent's Usual Occupat a kind of work done du DO NOT use retired) .sabled	ring most of wo		16b. Kind of Business None Maiden Sumame)	
Maryland	2 should and Mer ie marke	To Be	17. Father's Name (First, Middle, Last Cleo L. Floyd 19a. Informant's Name/Relationship		19b. Mail		Ann	Jenkins	or, City or Town, State,	Zip Code)
Baltimore, N	0 0		Valeria Evans — 20a. Method of Disposition 1 □ Burial 2 ③Cremation 3 □ 4 □ Donation 5 □ Other (Speci	20b. Removal from State	Place of Disponentery, cre	E St. SE osition (Name of matory or other place) itan Crema)	Date	a. DC 20019 20c. Location - City of Alexandria	Town, State
Baltii	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Lice 23a. Part / Enter the disease, or con	arshall	2 M 4	2. Name and Address [arshall's 217 9th St	of Facility Funeral N.W.	Home, I Washing	nc. ton, DC 20	
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P.O. Box	that the death certifica ed by the attending ph detached for use as th	nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknowh	23c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	livery Day Year
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Vital Rec	The ate h page	e Completed	25. Was case referred to medical				26. Place of De	24a. Was autop perfor 1 Yes	sy prior to death?	utopsy findings available completion of cause of
ō	ding Ph h. After th funeral	ation; To B	examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time of Injury	of 28c. Injury a	4 Nursing H	dome 5 ☐ Resid	lence 6 Other (Spenow injury occurred	acify)
Division	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	al Certification;	3 Suicide 6 Could not 1 4 Homicide determined	building, etc. (Spec	nowledge, dea	th occurred at the time	e, date and place	City or Tow	cause(s) and manner a	s stated.
•	To the Hos within 24 ho To the Fun completely	Medical	(Check only one) 2 Medical Example of Certifier 29b. Signature and title of certifier	miner: On the basis of examinand manner stated.	nation and/or in	29c. License	nion, death occu	urred at the time, o	date and place, and du 29d. Date signed (Mon	e to the cause(s)
K) — Sta	ate	30. Name and address of person who DAVID HOLD ACT 131. Date filed (Month, Day, Year)	completed cause of death (Ite	300	Print) HOSPI	TAL D	R. CHE	visely,	MD 20785

State of Maryland / Department of Health and Mental Hygienes Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** October 15 2004 5:45 A.M. Fowler Pear1 /Medical 4b. City, Town, or Locetion of Death 4c. County of Deeth 4a Facility Name (If not institution, give street and number) Examiner Montgomery Village Montgomery Village Care and Rehab. Montgomery if Under 24 Hrs Birthplace (State or Foreign Country)
 N • C • If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) Jan. 18,1914 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months 1 □ M 2 🛱 F 131-20-2097 90 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylen Dependruent of Health and Mertiel Hygiene.
Important: If Item 27 is marked other than "natural; or items 23a or 28a-f show eny Injury or other traumatic event, its Medical Examines must be notified as 17 Yes 2 □ No Director Montgomery Village Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20886 19310 Clubhouse Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Saltimore, Maryland 21215-0020 Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Family Services Social Worker 18 Mother's Name (First Middle Maiden Surname) 17. Father's Name (First, Middle, Last) Be Adelaide Susan Kistler Cowen Gray Hoover 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 506, LaPlata, MD 20646 John Moyer/ SOn - in - law 20b. Place of Disposition (Name of cemetery, crematory or other place)
Whiteville Memorial Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) October Whiteville, N.C. 23,2004 Cemetery 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer 21. Signature of Funeral Service Licer Park Drive, Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** . Sepsis /Medical Immediate Cause (Final disease or condition resulting in death) ovemonth Examiner Due to (or as a consequence of): De cub itus Examiner ulcer SACRUM After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last year Dementiu Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 2200 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4XNursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2X No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 X Natural 2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred of or Attending Picture of the form of the form of the form of the funeral d in by the funeral 5 Pending investigation 1 Yes 2 No To the Hospital or Atterwithin 24 hours efter destroy. To the Funeral Directo completely filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician. To the basis of my knowledge, death occurred at the time, date and place, and due to the educe(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Cutffier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature October 15, 2004 30. Name end ses of pe son who completed cause of death (Item 23a) (Type, Print) Cheryl Winchell MD 19241 montgomercy Village Ave, Mont vill. MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 19 2004 Registrar

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Physician /Medic Examin

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelih and Mental Hygiene. Important: If item 27 is marked other then "natural", or Items 23s or 28s-f show any injury or other treumait: event, The Medicul Egate and injurit by Excitited at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours efter death.

To the Funaral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

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Registrar

OCT 2 0 2004 >

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 15, Lydia Jane Friend October 2004 1:45 a M /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 269 Maple Street Friendsville Garrett If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yee Mar 21, 1 Birthplace (Stete or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 213-24-6279 75 1929 Director Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral', or itema 23a or 28a-f show Examiner must be netified at 1 XYes 2 □ No Friendsville MD Garrett Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 269 Maple Street 21531 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Item any injury or other traumatic event, the Medical Examinators. Black, White, etc. 1 □ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No white Specify: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Spear Izetta Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth L. Friend/husband 269 Maple St., PO Box 201, Friendsville, MD 21531 20b. Place of Disposition (Name of cemetery, crematory or other place)
Steele Cemetery 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct 18, 2004 Friendsville, MD *4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses Newman Funeral Homes, P.A., PO Box 275 179 Miller St., Grantsville, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Noma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4☐ Pregnant at time of death 5 Other (specify) signed by the aid be detached for ☐Yes 2☐No 9 Unknown 9 XUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ argunt with harysont my 1 - Yes 3 ☐ Probably 4 ☑ Onknown Completed 2 🗆 No peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 10 3 DOA this in by the funeral 27. Manger of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Alter 5 Pendina 1 WNatural 1 Yes 2 No investigation death. 2 Accident Director: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 256 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10701 New Heorge Creek S. W Frat Gung Hang Land 21532 & TURNINA CHANGUL. 1)

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

200k

William E. Fisher unknown 04-334 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-6636 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar DOS Reg. No. 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ε. 0705 a William Fisher 2004 October 14, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death
Prince Georges Examiner Brandywine SB Rt. 301 near Short Cut Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6 Sex 7 Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Washington DC Months 1 ☑ M 2 ☐ F Yrs. 218-90-8988 39 Aug. 26, 1965 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Show r than "natural", or itams 23a or 28a-f show the Medical Examinar must be multilled at 1 ☐ Yes 2 X No Maryland Charles Waldorf 28a-f Direct 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 7405 Bensville Road 20603 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: White 3 □ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Electrical Power Sys. Electrician ulth and Mental Hygie 27 is marked othar r traumatic avant, if 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Lerov Fisher Virginia Lee Sullivan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health a Virginia Hoover (Mother) 1120 Falmouth Road Waldorf Maryland 20601 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Department of Important: If it any injury or conce. 1 Burial 2 □ Cremation 3 □ Removal from State Oct. 20, Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Marvland 21. Signature of Funeral Service Liceosee 22. Name and Address of Facility Lee Funeral Home, Inc. MO1340 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tipe. Approximate Interval Between Onset and Death mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Ur denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed iding physician and ise as the burial-transil Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? λq a) INO 3 Probably 4 Unknown 1 Tes

Completed certificate has irector, page 2 Be P Certification: After

24a. Was an autopsy performed? Yes 2 🗆 No

24b. Were autopsy findings available prior to completion of cause of death? 2 No Yes

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) at SCENE

1 XYes 2 No 28a. Date of Injury 28b. Time of 27. Manner of Death 1 Natural 5 Pending investigation

28c. Injury at Work? Injury 04 065 Pice of Injury - At hor building, etc. (Specify)

1 Tes At home, farm, street, factory, office

28f. Location (Street and Number or Rural Route Number, City or Town, State) 301

29a Certifier

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time of the and place, and due to the cause Dlord

29b. Signatu and time of certifier

6 ☐ Could not be

determined

ccident

4 - Homicide

3 Suicide

29c. License number OCME 29d. Date sign d (Month, Day, Y ar) October 15, 2004

30. Name and address of person completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

28d. Describe how injury occurred

State Registrar

strar's Signature

this

Director: d in by the

Medical

To tha Hospital within 24 hours To tha Funarai

			For State Registrar	State of M	laryland / Dep <i>Ce</i>	artment of H		ental Hygier	Z 11114	34779
	Physici		1. Decedent's Name (First, Middle Barbara.	Christine	Fisher		2	2. Date of Death)av Voor	3. Time of Death 2:37 PM
	/Medio Examin		4a. Facility Nam <i>e (If not institution</i> 10203 Frank T	ippett Road		Chelt		4	c. County of Death Prince Geo	
	Funeral Director		5. Social Security Number 245 44 5026 Usual Residence of Decedent	6. Sex 7. A 1 □ M 2 □ F	nge (In yrs. last birthday 70 Yrs.	Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Yea July 23	r) Cour	place (State or Foreign ntry) orth Carolina
	the Maryland 28a-f show	Director	10a. State 10b. County	e George's	10c. City, Town or L	eltenham		10a. (Citizen of What Cou	0d. Inside City Limits 1 Yes 2 No XX
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural', or iteme 23a or 28a-f show entry injury or other traumatic event, Ira Madical Examinant uset be neitlind at anone.	by Funeral	10203 F 11. Marital Status 1 □ Never Married 2 □ Man 3\text{XWidowed} 4 □ Divorced	rank Tippet 12. Was Deceden Armed Forces 1	ot Ever in U.S. 13.		20623 spanic Origin? (Spec n, Mexican, Puerlo Ri Specify:		United St 14. Race - Americ Black, White, Specify:	cates ean Indian,
Maryland 21215-0036	ad within 72 ho giene. er than "natur t, tre Medical I	Completed	(Specify only highe Elementary/Secondary (0-12) 12	t's Education st grade completed) College (1-4or	(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	ation Juring most of working)	7	Kind of Business/In	
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re, Mai	is 1 and 2 st of Health and item 27 ie n other traun		19a. Informant's Name/Relations Vicky Perry 20a. Method of Disposition		102	03 Frank	rippett Ro Oct 26, 2	ad, Chelt		ryland
Baltimore,	mit. Pages bartment of bortant: If it injury or c		1 X Aurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service	pecify)	Rutherfo	rd County	Memorial s of Facility Lee	Cemetery		
Ä	Dermi Depa impo eny ir		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	O 1340 A	lexandria	Ferry Roa	d, Clinto		
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. CQ	s a consequence of):	ma o.	flung	3		Onset and Death
,8760,	death certificate be executed e attending physician and d for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	s a consequence of):					
O. Box 6	death certific e attending p ad for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ory Day Year
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	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) 2	g Physician: To the bes Exeminer: On the basis and manner s	of examination and/or in	th occurred at the tim evestigation, in my op 29c. License	inion, death occurred	at the time, date a	s) and manner as st nd place, and due to ate signed (Month, a	the cause(s)
	F 3 F 8		30. Name and address of person	Jaly	death (Item 22a) (Time	DY	6478		-18-01	-
0	.69		Surresh Pate1 31. Date filed (Month, Day, Year)	M.D. 7501	Surratts Ro	oad #307,	Clinton, M	Maryland	20735	
	Sta Registr		OCT 1	9 2004	trar's Signature	protection				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Raymond Alvey 2:00A M Fox October 15 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Solomons

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 28, 1920 Washington, DC Solomons Nursing Center 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1₩ M 2□ F 84 578-14-8373 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits Hygiene. other than "natural", or Items 23a or 28a-f show ant, the Madical Ever ther treat by molith-d at 1 ☐ Yes 2 ☑ No Director St. Mary's Mechanicsville Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29875 Washington Rd. 20659 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronics Technician U.S. Government other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be fil Health and Mental H tem 27 Is marked otl Harry Fox Pearl Alvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l Martin Rd., Brandywine, MD 20613 Robert Fox/son 13755 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Oct. Daile. permit. Pages 1
Department of H
Important: If ites
any injury or oth Charlotte Hall, MD 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols crematory 2004

22. Name and Address of Facility Brinsfield-Echols Funeral Home, ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Best P.A., 30195 Three Notch Rd., Charlotte Hall, MD Who mores Approxim 0622 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final DISEASE CORONAR Pnysician Several disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or certying Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai e attending p. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9□ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď gig a 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I or Attanding Patter death.

Director: After 1 After 5 Pending М 1 🗌 Yes 2 No investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10-15-2004 30. Name and address of person who completed cause death (Item 2 a) (Type, Print)

State Registrar Anwar Munshi, Prince Frederick, MD
31. Date filed (Month, Day, Year) 32. Afgistrar's Signature

OCT 2 0 2004



			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of H			ene 004	3471	81
	o		1. Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of D)eath
	Physici Medic/		Angela Giovanna	F1anagan				Month October	15, 2004	12:58	P^{M}
	Examin		4a. Facility Name (If not institution	n, give street and number	")	4b. City, Town, or	Location of Death		4c. County of Dea	th	
			Anne Arundel Me			Annapoli			Anne Aru	nd e1	
	Funeral		5. Social Security Number	6. Sex 7. A 1 M 2XXF	ge (In yrs. last birthday) 70 vrs	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	rear) Co	thplace (State or a	Foreign
	Director		070-28-9259 Usual Residence of Decedent	12 240	70 Yrs.			June 23,	1934 New	York	
	land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City	Limits
	Mary f sh	ō	Mars. 1 a.s. 1 A.s. a	A 4 1	A1					1 X Yes 2	
	r 28a	Director	Maryland Anne . 10e. Street and Number	Arundel	Annapolis	10f. Zip Code		10	g. Citizen of What Co	ountry?	
	3a o	Ö	1703 Cedar Park	Road		21401		I	nited Sta	tes	
	deatl	Funerai	11. Marital Status	12. Was Deceden		Was Decedent of Hi	spanic Origin? (Spe	ecify Yes or No-	14. Race - Ame	erican Indian,	
9	after or Ite		1 ☐ Never Married 2 Mari	Armed Forces ned 1 ☐ Yes 2 ∑ If Yes, Give	No	If Yes, specify Cubar 1 ☐ Yes 2 🌠 No	Specify:	Hican, etc.)	Black, Whit		
8	be filed within 72 hours after death with the Maryland to Hyglene. Hyglene death Hyglene death of ther than "natural", or tems 23a or 28a-f show other than "natural", or tems 23a or 28a-f show awent, the Medical Examinar round be notified at	d by	3 Widowed 4 Divorced	Year or Dates:			Specify.		Specify: W	nite	
<u>7</u>	natu	Completed	15. Deceden (Specify only highe	it's Education st grade completed)	(Give	dent's Usual Occupa kind of work done d	furing most of worki	ing 10	6b. Kind of Business	/Industry	
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20	e filed within al Hyglene. I other than '	e Co	12 17. Father's Name (First, Middle,	Last)		Home Make	18. Mother's Name	/First Middle Mi	Own Home	е	
an	d be ental ced o	00	Phillip Ciampag				Dora DeJ		ardon damano,		
Maryland 21215-0036	2 should be and Mental Is marked (raumatic ev	T ₀	19a. Informant's Name/Relations		19b. Mailir	ng Address (Street a			City or Town, State, 2	Zio Code)	
Ž	nd 2 alth a 27 ls		John D. Flanaga	n / Husband					, Marylan		
Je,	s 1 a		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other place			Oc. Location - City or		
Ē	Page nent ant: If ary or		1 XX urial 2 ☐ Cremation 1 4 ☐ Donation 5 ☐ Other (S			s Cemete:		/2004 A	nnapolis,	Mary1an	d
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic e once.		25 Signature of Funeral Service	Licensee	22	. Name and Addres	s of Facility	John M.	Taylor Fu	neral Ho	me
	205 2 9		Joan	e, mil	le l	147 Duke o			Annapol:		
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not ent line.	er the mode of dying	g, such as cardiac o	or respiratory arres	it,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Ly	mo ham	a				Onset and De	ath
	/Medical Examiner		resulting in death)	Due to (or a	s a consequence of):						
		<u>.</u>	Sequentially list conditions,	b. — Due to (or a	s a consequence of):						
	ted is	nine	if any, leading to immediate cause. Enter Underlying that initiated events	d Sue to (or as	s a consequence on.						
	and and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or a	s a consequence of):						
8760,	death certificate be executed e ettending physicien and id for use as the burial-transit	dicai E		d							
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Вох	leath certific ettending p	N/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			23d. Date of deli	ivery	
	ed for	sicie	in the past 12 months?			Other (specify)			Month	Day Yea	ar
P.0	that the de led by the e detached t	Physician/Me	9 Unknown								
Ś	se ngi	by	Part II. Other significant condition	ons contributing to death i	but not resulting in the u	nderlying cause give	n in Part I.		cco use contribute to		
Records,	w requir been s should	Completed						1 ☐ Yes	2,200 3 □ Pr	obably 4 🗆 Uni	Chown
360	e la has je 2	mpi						24a. Was an autopsy performe	prior to d	topsy findings ava completion of caus	ailable se of
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Vital) Be	25. Was case referred to medical examiner?	Hospital:		t all pay Other	26. Place of Death				
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Division	Atte ecto by th	iffica	3 Suicide 6 Could i	inad 286. Place of in	ijury - At home, farm, str tc. (Specily)	eet, factory, office	2	28f. Location (Stree City or Town,	et and Number or Ru	ral Route Numbe	r,
	tal or	Certification;	Tomodo .	building, e	ic. (Specify)		ļ	City of Town,	State)		
	Hospital or 24 hours afte Funeral Dir tely filled in I	icai	(Check only 2 Medical	ng Physician: To the best Examiner: On the basis of	of my knowledge, death	occurred at the time	e, date and place, a	and due to the caused at the time, date	se(s) and manner as	stated.	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical	one) 29b. Signature and title of certifie	and manner s	tated.	29c. License					
ļ	8 1 ½ H		230. Signature and this bit contino	4/	MA	1) (TXT	230	Date signed (Month	A LI	
			30. Name and address of person	who campleted cause of	death (Item 22s) (Time	Print) A	7 10 1		1 1 1 3 /	7	1
			A con e e		edical Pkwy		tona P	1	(M)		ter
	₈ Sta	te	31. Date filed (Month, Day, Year)	32. Regis	ar's Signature	י דוויד	, nne 1	31 - W UT T	1 1701	160	110
	Registr	ar	UCT	1 8 7004	me &	Book :					

State of Maryland / Department of Health and Mental Hygier 001 34782 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TACK 4:00 AM FRUST October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 617 Park Place Deale Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign May 1202), Yaag 22 In diatra 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**XX**M 2□F Days Hours Min. 82 Yrs. Director 579-20-6444 Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits rel', or Items 23e or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Directo Maryland Anna Arundel Deale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 617 Park Place 20751 United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3XXWidowed 4 □ Divorced "neturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) then Elementary/Secondary (0-12) College (1-4or 5+) Mechanical Engineer U.S. Navv and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward V. Frost Ethel Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health ar
Importent: If item 27 is Linda Frost / Daughter 206 Victor Parkway Apt G Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 □ Burial 2 Cremation 3 □ Removal from State Date 20c. Location - City or Town, State 10 ' 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 10/16/2004 Faltimore, Maryland
22. Name and Address of Facility

Take M. Taylor Fundant III. 21. Signature of Funeral Service Licensee John M. Taylor Funeral Home Mich 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the direction ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final UNKNOWN PRIMARY YRS **Physician** METASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed l 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed 1 Yes 2 No 1 Yes 2 🗆 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours after To the Funerel Dire descriting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Mgnth, Day, Year) 29b. Signatu/e and title of certifier yarves 105158 10/14/2004 klel 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6131 SHADY SIDE ARVe. TEINFELD SHARY SIDE 31. Date filed (Month, Day Year) 2004 Regis r's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 👢 34783 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Raymond Fountain October 15 2004 2:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Galesville
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Taniary 17 957 Galesville Road Anne Arundel 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) 1925 Maryland 5. Social Security Number **Funeral** January XXM 2□ F Yrs. 79 Director 214-14-9658 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel 1 Tyes 2 No Galesville 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a or 957 Galesville Road 20765 Pages 1 and 2 should be filed within 72 hours after death vent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23 USA Funera 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Pyes 2 No trYes, Give Year or Dates: W.W.II 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5th Self Employed Waterman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ George Fountain Anna Mae Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 957 Galesville Rd. Galesville, Md. 20765 Agnes Fountain (Wife) 20b. Place of Disposition (Name of crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permil. Pages 1 Department of H Important: If ite any injury or ot once. cemeter, crematory or other place)
Maryland Veteran
Cemetery 1- Surial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 10/20/04 Crownsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Reese West Sons Mortuary, Annapolis, Md 23a. Part. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pan creatic **Physician** Carcynome 13 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) ٩ 1 Yes 2 No 3□ DOA : After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Naturat 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier

State Registrar

D

29b. Signature and title of certifier

- OJ

itusin

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Perbaum

29c. License number

038563

29d. Date signed (Month, Day, Year)

October 13, 2004

State of Maryland / Department of Health and Mental Hygien 200 l. 34784 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Margaret Feldman Month 10 14 2004 3:35 \mathbf{P}^{M} /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Hebrew Home - Wasserman Bldg. Rockville
If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√F Months Days Hours 82 Yrs. Director 069-14-4723 Hungary 11-14-1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. If them 27 is marked other then "neturel", or items 23e or 28e-f show 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Maylical Examinations to inclined at 1 ☐ Yes 2 ☐ No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Completed by Funeral 6121 Montrose Road 20852 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Herman Berger Ethel Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5450 Whitley Park Terrace #811, Bethesda, No 20814 Max Boyarsky, Brother in Law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 00 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Importent: If any Injury or once. Mount Lebanon 10-17-2004 * 4 ☐ Donation 5 ☐ Other (Specify) Adelphi, MD 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee to 11800 New Hampshire Ave, Silver Spring MD 20904 rart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and if heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RE BRAL 14 ROMBOSIS **Physician** disease or condition resulting in death) WEEKS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter underlying Cause (Disease or injury that is its total cause). Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year 5 Other (specify) o 9 Unknown 9 Unknow نه Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, FIBRI LLATION No 3 Probably 4 □Unknown 1 🗌 Yes Completed HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Vital funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Ceath 28b Time of 28d. Describe how injury occurred After Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No filled in by the Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire ō Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TROSE C12, MCA ATEC, MO. 31. Date filed (Month, Day, Year) OCT 18 32. Registrar's Signature State Registrar Darker.

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State of Maryland / Department of Health and Mental Hygien 34785 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year OCTOBER 18, CHARLES RAY GRUBB 2004 10:50 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUPPETT & WEEKS NURSING HOME OAKLAND GARRETT If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) FEB 25, 1938 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2□F MARYLAND 212-38-5162 66 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23e or 28a-f ahov It e Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD GARRETT OAKLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7613 GORMAN ROAD USA 21550 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) othar than Hygiene. SALES CLERK LUMBER COMPANY 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itam 27 is marked oth any niury or other traumatic event ADEs. 18. Mother's Name (First, Middle, Maiden Sumame) Be HARRY BEST RUTH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LOIS MARTIN - PERSONAL REP. 9605 GARRETT HIGHWAY OAKLAND, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State *4 ☐ Donation 5 ☐ Other (Specify) POPE CEMETERY 10/21/04 OAKLAND, MARYLAND 21. Signature of Funeral Service 22. Name and Address of Facility P.O. BOX 243 M00167 Kolm DURST FUNERAL HOME - OAKLAND, MD 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Stolie if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page performed? 1 Yes 1 ☐ Yes 2 ☐ No 2 No Division of Vital To the Hospital or Attanding Physicien: 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi: funeral o 28a. Date of Injury (Month, Day Year) 27. Manner of De th 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

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completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Might Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) margaret a Ka.
31. Date filed (Month, D) (Colar) 2 13079 mor 20042. Registrar's Signature State Registrar

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2	er de Items	une	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (S Juban, Mexican, Puer	Specify Yes or No to Rican, etc.))- 14. Ra	ace - Americ ack, White,	
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LU		30. Name and address of person who co	ompleted cause of death (Iter	7 23а) (Туре,		Stree	t, Baltimo	ore, Ma	rylan	d 21201
S Regis	ate	31. Date filed (Month, Day, Year) OCT 2 0 2004	39. Registrar's Signa	ature						

			For State Registrar	State of I	Maryland	/ Depa	artment of H	lealth a	and Men	ntal Hygi	ene 0 0	4	34788	
			1. Decedent's Name (First, Middle, Last)				2. Date of Death					3. Time of Death		
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	Examin		4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				,	4c. County of Death		
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if team 27 la marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic event, it a Marical Exertication and injury or other traumatic event, it a Marical Exertication and once.	_	10a. State 10b. County		10c. City,	Fown or Lo	ocation					1	Od. Inside City Limits	
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ary		-	19a. Informant's Name/Relationship	(Type, Print)	5	19b. Maili	ng Address (Street a				City or Town,	State, Zip	Code)	
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altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	□Removal from Sta	20b. Plac	e of Disponetery, crea	sition (Name of matory or other plac	ee)	Date	26	Oc. Location -	City or To	wn, State	
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Ball			21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011											
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	To the Hospital within 24 hours a To the Funeral E completely filled in		29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. [Check only one] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											
	To th within To th		29b. Signature and title of certifier		<i>r</i> .		29c. License	number		290	d. Date signed	(Month, [Day, Year)	
_	. > - 0		D 11. 30	wans	und.	W	105	336	7	0	(TOBET	2171	h 2004	
2			29b. Signature and title of certifier 1. Suyum Sum 29b. Signature and title of certifier 29c. License number 29c. License number 29d. Date signed (Month, Day, Year) 0(TDBL*N 1 7 11, 2iv 4, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 8 0 DALNESTOWN ROAD SUINS 200, GAMMENUM, MD; 20877,											
	4			3 TOWN RU			UL, UM	71111	UPVA	n, riv	10011	,		
		State Registrar 31. Date filed (Month, Day, Year) Registrar 0CT 1 9 2004												
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State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:20 A^M Mollie October 17, 2004 Greer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3706 Cool Crest Drive Jefferson Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 31 Virginia 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2√F 73 Yrs. 224-36-3726 1931 Director September 1, Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ms 23a or 28e-f show Jefferson Frederick Maryland 1 ☐ Yes 2√No **Funeral Director** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3706 CoolCrest Drive 21755 items 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 X Married 0 white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ANO Specify: Specify. Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 90 10 Homemaker Own home .. Pages 1 and 2 should be filed v treent of Health and Mental Hygie tant: If item 27 is marked other t ilury or other treumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Flora Lockhart Marvin Hall 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3706 Cool Crest Drive, Jefferson, Maryland Kathy Becker - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If any injury or once. Resthaven Memorial 10-21-2004 Frederick, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 Sharow Camille Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician -ardiomy or athy 6 mest /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 sesidence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 | Homicide within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed. (Month. Dav. Year) 29b. Signature and title of certifier MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 65-6, Thomas DV Johnson 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

4-6	6693		Please	Type or Print in Black in			•	•	
1			For State	State of Maryland / Dep					21700
			1 - State Registrar		ertificate of	Death		Reg. 2.004	34790
	Physicia	an	Decedent's Name (First, Middle, Las.				2. Date of Dea Month	ntn Day Year	3. Time of Death
	/Medic	al	David Robert Ge		4h City Tourn	or Location of Death	October	r 16, 2004 4c. County of Dea	4:44 P M
	Examin	er	4a. Facility Name (If not institution, give						.10
	Funeral		I 70 WB @ Watersv: 5. Social Security Number 6. Se		Fredric If Under 1 Year		8. Date of Birth	HOWARD 9. Bir	thplace (State or Foreign
	Director		225-04-0817	☑ M 2 ☐ F 45 Yrs.	Months Days	Hours Min.	October	22, 1958	rthplace (State or Foreign ountry) California
	P.		Usual Residence of Decedent	100 Ch. 7					
	shoy	<u></u>	10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M	ecto	Maryland Frederic	ck Frederi	LCK 10f. Zip Code		···	10g. Citizen of What C	
	72 hours after death with the Maryland naturel', or Items 23a or 28a-f show iteal Examinat must be indiffed at	by Funeral Director	3760 Hope Commo	ons Circle	2170	04		U.S.A.	Juliuy :
	ns 23	era	11. Marital Status			Hispanic Origin? (Spe an, Mexican, Puerto I	cify Yes or No-	14. Race - Am	
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03	ral', c	l by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 12 Year or Dates:	1 ☐ Yes 2€ No			Specify:	WIIICC
215-0036	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation 16a. Deci de completed) (Giv	edent's Usual Occup e kind of work done	pation during most of workind)	ng	16b. Kind of Business	/Industry
121	within in the in the interest	d d	Elementary/Secondary (0-12)	College (1-4or 5+)		^{a)} Marketing		Telecommun	ications
121	filed v Hygie othar t		17. Father's Name (First, Middle, Last)	t Arce i	resident	18. Mother's Name			.104010110
and	ould be f Mental I warkad of	o Be	Robert F. Gelle	rman		Donna Gil		,	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. Itam 27 is marked other than "netural", or Items 23a or 28a-1 show itam 27 is marked other than "netural", or Items 23a or 28a-1 show other traumatic evant, the Medical Examinar must be rediffed at	၉	19a. Informant's Name/Relationship (7	Type, Print) 19b. Mai				r, City or Town, State,	
	1 and 2 s Health ar am 27 is		Eileen Gellerman	- Ex wife 364	4 Islingt	on Street,	Freder	ick, Maryl	and 21704
Baltimore,			20a. Method of Disposition	20b. Place of Disp	oosition (Name of ematory or other pla		ate	20c. Location - City or	Town, State
Ē	permit. Pages Department of I Important: If iti any injury or o		1 ☐ Burial 2 🏝 Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Hemoval from State	k Cremato		-2004 I	Frederick,	Maryland
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	/Medical Examiner		Tosuming in death)	Due to (or as a consequence of):					
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68	tificat ng ph) as th	Physician/Medi	15.55.111.5						
Box	th cer lendir r use	an/N	23b. was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnanc	v		23d. Date of de Month	
	Q 0 Q	sici	in the past 12 months? 1 Yes 2 No		Other (specify)			Month	Day Year
P.0	ires that the de signed by the a 1 be detached t	Phy	9 Unknown	ontributing to death but not resulting in the	underhing cause on	von in Part I	23e Did to	bacco use contribute t	o the cause of death?
S,	law requires that the as been signed by th 2 should be detache	by	Part II. Other signmeant conditions of	Attributing to addition for the stating in the	andenying cause go	voir art art i.	1 🗆 Y	A- C	robably 4 □Unknown
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Vital	Physician: this certific ral director,	To Be	examiner? 1X Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	ent 3 DOA Ott	her: 4 \(\sum \) Nursing Hor		700	ecify) scene
of	g Phys er this eral di		27. Manner of Death	28a. Date of Injury 28b. Time (Mol P. Da Year) Injury	of 28c. Inju			ow injury occurred	Scene
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<u> </u>	r Atta er de recto	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	8e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	/ \	28f. Location (S Cir or Tow	treet and Number or R	ural Route Number,
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	Hosp 4 hot Funa lely fil	ical	(Check by 2X Medical Exan	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or i					
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Director: After th completely filled in by the funeral	Medical	29b. Signature and title of certifier	and than of station.	29c. Licens	se number	2	29d. Date signed (Mon	th, Day, Year)
	T W S		Val.	(ALC)				-	
			30. Name and address of person who	completed cause of death (Item 23a) (Type	a. Print)	OCME	(October 17	, 2004
	10	-	J. A. Ron	11 × = 0		Baltimore,	Marrola	nd 21201	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	4		наступа	AL GIGVI	
	Regist	rar	nct 1	9 2004 Senera	N M	Darks			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 004 34791 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician October 2004 2:15 a M /Medical Chester Gilbert 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Summerville at Westminster Westminster Year If Under 24 Hrs. Carrol1 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, NOV 09 9. Birthplace (State or Foreign Country) Kentucky **Funeral** 1 QM 2 □ F Days Hours ^Y1921 Months 401-28-9953 82 Yrs **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or flems 23a or 28a-f show other traumatic avant, the Medical Examiner must be notified at Director 1 ZYes 2 No Carroll MD Westminster 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. e filed within 72 hours after d. Il Hygiene. othar than "naturaf", or ftem 1 XYes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates: þ Specify 3 Moldowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Educator/Principal Education othar 1 6+ permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Itam 27 is marked otha any injury or other traumatic accent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Gilbert Delania Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Raymond Gilbert/son 37 Heritage Lake Drv Bluffton, S.C. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 월 Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Crestlawn Cemetery 10/18/2004 Marriottsville, MD `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Pritts Fureral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that dauged the death. Do not enter the mode of dying, such as cardiac or aspiratory arrest, shock, or heart failure. List only one cause on seen line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Due to (or as a consequence of):

Diabeles /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate 1 Yes 1 Yes 2 🗆 No To the Hospital or Attanding Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To tha Funaral Diractor: 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) d address of person who completed cause of death (Item 23a) (Type, Print) Poole Road, Westminster 31. Date filed (Month State Registrar

			For State Registrar	State of	Maryland / Do	epartme C <i>ertifica</i>	ent of H ate of L	ealth a D <i>eath</i>	and M	ental Hyg 8	ienze O	04	34792
			1. Decedent's Name (First, Middle, L	ast)						2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medic		George Francis	Gallagher						October			19:40P M
>	Examin		4a. Facility Name (If not institution, g	ive street and numb	per)	4b. Ci	y, Town, or	Location of	of Death		4c. Cou	unty of Deat	h
			Montgomery Gene			dout If I lo	Oln ler 1 Year	ley If Under:	24 Hrs	8. Date of Birth		ntgom	ery hplace (State or Foreign
	Funeral			Sex 7. 11 M 2 F	Age (In yrs. last birth	Month		Hours	Min.	(Month, Day	, Year)	Co	ountry)
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	yland		10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
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	er de Itema	Funeral	11. Marital Status 1 □ Never Married 2 ⅓ Married	12. Was Decede Armed Force 1 Tryes 2	es?	If Yes, s	pecify Cuba	spanic Ori n, Mexican	gin? (Spe 1, Puerto F	cify Yes or No- Rican, etc.)		Black, White	
39	irs aft	by F	3 Widowed 4 Divorced	If Yes, Give Year or Date		1 🗆 Yes	2 ₩ No	Specify:			Spe	ecify:	Thite
Š	within 72 hours after death with the Maryland ene. than "natural", or Itema 23a or 28a-f ehow I'w Modical Evanirer mast be notified at	ted	15. Decedent's	Education	16a. I	Decedent's U	sual Occupa	ntion	t of working		16b. Kind o	of Business/	
215	thin 7 e. en "n	Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4		life. DO NOT	use retired)	t or workii	'y			
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Maryland 21215-0036	d 2 sl th and th and traur		Catherine C. Ga)5 Tarl	,						land 20906
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Itema 23a or 28a-1 ehow any injury or other traumatic event, the Modical Evantings must be notified at once.		20a. Method of Disposition	<u> rragiler</u>	20b. Place of I	Disposition //	lame of						Town, State
9	Pages entol nt: If		1 Burial 2 □ Cremation 3 14 □ Donation 5 □ Other (Spec		ate Gate of	Heave		" i	Oct 1	8,2004	Silva	r Sar	in MD
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Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	ome of pregnancy th 2 Fetal death	3 □Ectopic					23d.	Date of del Month	ivery Day Year
0	the dea by the a	Physiclan/Me	1 Yes 2 No	4∐Pregnar 9□ Unknow	nt at time of death vn	5 🗌 Other	(specify)						
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	The law ate has b page 2 s.	ompleted								autops perfori 1 Yes		prior to death? 1 ☐ Yes	completion of cause of 2√2 No
Vital		C	25. Was case referred to medical					26. Place	of Death	(Check only or			
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Division	in the	Certification:	4 Homicide determine	ad 28e. Place o	of Injury - At home, far g, etc. (Specify)	m, street, fac	ory, office		4	City or Town		JINDER OF HE	ural Route Number,
	Hospital 24 hours a Funeral C		29a. Certifier 1 X Certifying	Physician: To the b	pest of my knowledge,	death occurr	ed at the tim	ne. date an	nd place, a	and due to the c	ause(s) and	manner as	s stated.
	e Hos 24 h Fur etely	edical			sis of examination and								
	To the Hospital within 24 hours a To the Funeral completely filled	Me	29b. Signature and tille of certifier				29c. License	number		2	9d. Date si	gned (Mont	h, Day, Year)
	11		1 / 14				D 356	535		(ctobe	r 15,	2004
	(0+)		30. Name and address of person wh	no completed cause	of death (Item 23a) (Type, Print)							
			Joseph Kaplan,		3111 Prince	e Phil	ip Dri	Lve !	01ney	, Maryl	Land 2	0832	
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 18 20		gistrar's Signature	Sou	uks/	,					
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			For State	State of Marylan		ent of He		lental Hyg	iene n n l	31,793
	¢° .		Registrar 1. Decedent's Name (First, Middle, Last)	1		ale of L	<i>Jeath</i>	2. Date of Death		3. Time of Death
	Physici /Medi	al	MATTIE 4a. Facility Name (If not institution, give s		HUWARD	City Town or I	Location of Death	October	Day Year 16 200	1100
	Examir	ier	Peninsula Legione	I Medical a	enter	Salis	b/4		4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex	M 2 XF 7. Age (In yrs. I	Yrs. If U	nder 1 Year ths Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
	land DW		Usual Residence of Decedent 10a. State 10b. County		/, Town or Location			70 510		10d. Inside City Limits
	ne Marylan 8a-f show	ctor	MD Somers	et P	Cincess	Ann	e			1 X Yes 2 □ No
	ours after death with the Maryla rat", or Items 23a or 28a-f shor Examiner must be notified at	Funeral Director	30777 Division	in ST.	1 Of	Zip Code	53	10	og. Citizen of What Co U.S.	- 11.
6	items 2	uner		2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 🛣 No	S. 13. Was D		panic Origin? (Spe , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ha Madical Examirer must be notified at	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 □ Ye	s 2 No	Specify:		Specify: B	lack
21215-003	hin 72 t e. an "natu Madica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Decedent's l (Give kind o life. DO NO	Jsual Occupat f work done du T use retired)	tion uring most of worki	ng 1	6b. Kind of Business	Industry
d 21	filed with Hygiene. othar than	Con	17. Father's Name (First, Middle, Last)		Lin	-	ORKEY		amphell	Soup Co.
Maryland	Mental Mental arkad c	To Be	Charles Nixon	1			MARY	New	comb	
Mar	and 2 sho salth and n 27 Is ma		19a. Informant's Name/Relationship (Typ MAHIE Johnson -	Daughter					City or Town, State, I	
Baltimore,	permit. Pages 1 and 2 Department of Health Important: If itam 27 any injury or othar tra once.		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	moval from State	lace of Disposition (emetery, crematory	Name of or other place,)	ate 2	0c. Location - City or	Town, State
altim	permit. Par Department Important: any injury once.		4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		Mark U.M.	and Addrose	of English		Daksville,	MD
ä	Deg Imp		JAS. Low.	7,0	Arty	100339 E	ampain A	ineral Ho	ess thre	10.2185
ı	Pnysician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Final disease or condition	ations that caused the death e cause on each line.	ASC		, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
1	/Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	ience of):					Syear
		ner	Sequentially list conditions, if any, touching to immediate cause. Enter Underlying Cause (Disease or injury	Che to (or as a consequ		BLEED				2 days
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ		MONARY	EMBOL	ISM		one day
8760,	ate be e hysiciar the buri	dicai E	d.							
Box 6	eath certific attending p I for use as	n/Mec	IF FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna					23d. Date of del	Verv
.O. B	requires that the death certific een signed by the attending p nould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown		c pregnancy (specify)			Month	Day Year
٩	es that the igned by be detact	by Ph	Part II. Other significant conditions cont	ributing to death but not resu	Iting in the underlying	ng cause given	in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ord		eted						-	2 No 3 Pr	
of Vital Records,	: The law cate has b ; page 2 si	Completed						24a. Was an autopsy perform	prior to d	topsy findings available completion of cause of
Vita	sician: certific rector,	Be	25. Was case referred to medical examiner?	spital:	- D/O		26. Place of Death	Check onl one)	
n of		on: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury a Work?	4 ☐ Nursing Hon at 2	ne 5 ☐ Residen 8d. Describe how	ce 6 Other (Spec vinjury occurred	ify)
Division	E = :: 0	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hor	me, farm, street, fac		es 2 🗆 No	8f. Location (Stre	et and Number or Ru	ral Route Number,
Ö	pital or		4 Homicide	building, etc. (Specify			-	City or Town,	,	
	To the Hospital or Atta within 24 hours after des To tha Funaral Directol completely filled in by th	edical	29a. Certifier (Check only one) 1 ☐ Certifying Physi 2 ☐ Medicel Exemine	cien: To the best of my know er: On the basis of examinati and manner stated.	viedge, death occur ion and/or investigat	red at the time tion, in my opin	, date and place, a nion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	/		29c. License r			d. Date signed (Month	
			30. Name and address of person who com		23a) (Type, Print)	2031	->7		Oct 18 1 2	004
	Sta	te		32. Registar's Signat		70 2150	4			
	Registr		OCT 1 9 2	32. Registar's Signat	& Son	ule)				

State of Maryland / Department of Health and Mental Hygiene 004 34794 State
Registrar AMEND#18perINF10/20/04, BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OCT. 13, Day 2004 **Physician** Estelle Dolores Hermann 9:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner CARRIAGE HILL N.H. **BETHESDA** MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | MAY 11, 5. Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F 1914 329-18-9856 90 ILLINOIS Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10h County 10d. Inside City Limits 28e-f show the Medical Examiner must be notified at IL. WINNETKA 1 ☐ Yes 2 No Director 10e. Street and Number 680 GREENBAY RD. 10g. Citizen of What Country? USA 10f. Zip Code 60093 Items 23a by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 21215-0036 ò WHITE 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 HOUSEWIFE OWN HOME 18. Mother's Name (First, Middle, Maiden Symame)
Anna Dziemienoski Maryland 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked off jury 95 other troumatic even WALTER BECKO 2 19a. Informant's Name/Relationship (Type, Print) BEVERLY MALATESTA/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 X Removal from State permit. Page Department of Important: If any Injury of once. 4 ☐ Donation 5 ☐ Other (Specify) RIDGEWOOD FH.&MEM PK. 10/19/2004 DES PLAINES, ILLINOIS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JOSEPH GAWLER'S SONS INC., 5130 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MONTHS Death Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ISCHEMIC CARDIO MYOPATHY YEARS Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. attending physician Physician/Medical the use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 XNo 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 6 should be PELVIC MASS UNKNOWN ETIOLOGY, ASCITES ATRIAL 1 Yes 2 No 3 Probably 4 Unknown Completed been FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a. Was an page 2 autopsy performed? certificate 1 X Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title 29d. Date signed (Month, Day, Year) certifier 29c. License number 1 mo D35579 10/14/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN MILLER, MD., 6844 TULIP HILL TERR., BETHESDA, MD. 31. Date filed (Month, Day, Year) Registrar's Signature State

Registrar

19 2004

			For State Registrar	State	of Marylan	d / Depa <i>Cei</i>	artment of H	lealth ar Death	nd Mental Hyg	giene 0	04	34795
Ì	Physicia /Medic		1. Decedent's Name (First, Middle, SAMOIL	Last)	HEI	LFM	AN		2. Date of Dea Month OCTOBE	Day	Year 2004	3. Time of Death 2:00 A M
H	Examin		4a. Fecility Name (If not institution, Hebrew Home of (on	4b. City, Town, o		Death	4c. County	of Deeth	rv
	Funeral Director			6. Sex 1 ∑ M 2 □ F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24	Hrs. 8. Date of Birt Min. (Month, Da March 1	h y, Year)		lace (State or Foreign atry)
	iryland thow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	th the Ma or 28a-f	Funeral Director	Maryland Montgo	omery		Roc	kville 10f. Zip Code			10g. Citizen of	What Cour	1 Xes 2 No
	23a	ral	6105 Montrose Ro				208			United		
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f show is marked other than "natural", or items 23s or 28s-f show aumatic event, the Marical Examiner mant be notified at	by Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☒ Widowed 4 ☐ Divorced	Armed	ecedent Ever in U. Forces? s 2X No Give Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)	14. Rad Bla Specif	ce - Americ ck, White, 'y:	
Maryland 21215-0036	hin 72 hou s. nn "natura Madical E	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade complete	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most o	f working	16b. Kind of 8		
7	ed witi	Com	12			Lab	oratory T			Spice		any
land	uld be file Aental Hy rked oth tic event	To Be (17. Father's Name (First, Middle, L David He	ast) elfman					s Name <i>(First, Middle,</i> olda Butz		_{ne)} Cahana	a
Mary			19a. Informant's Name/Relationshi Giselle Schwartz		hter				or Rural Route Number			
	permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra		20a. Method of Disposition 1 🖁 Buria 2 🗆 Cremation		20b. P	Place of Dispo	esition (Name of matory or other place	ce)	Date	20c. Location	- City or To	wn, State
Baltimore,	permit. Pag Department Important: I any injury o		*4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L.	ecity)	Ju				s 10/20/04 neral Direc			yland
ñ	Per il De		230 Park Enter the disease or	mplications tha	frui	1	091 Rockv	rille P	ike, Rocky	ville, M		0852 Approximate
	Physician		23a. Part. Enter the disease, or of shock, or heart failure. List of limmediate Cause (Final disease or condition	nly one cause of			GART FA			1651,		Interval Between Onset and Death
3	/Medical Examiner		resulting in death)	Due H	o (or as a conseq		10N					
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 1	o (or as a conseq	uence of):						
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dicai Exa	that initiated events resulting in death) Last	C. Due	o (or as a conseq	uence of):						
9	tificate ig phy as the	ledic		U								
O. Box	ne death certifi the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of preg <i>n</i> a a birth 2 ☐ Feta agnant at time of d known	death 3	Ectopic pregnancy Other (specify)				te of delive onth	ory Day Year
rds, P.	law requires that the de as been signed by the a 2 should be detached f	by	Part If. Other significant condition SENILE	os contributing to	death but not res	ulting in the u	nderlying cause give	en in Part I.		obacco use cont	tribute to th	e cause of death?
Vital Record	The ate h	Completed							24a. Was autop perfor	sy med?	death?	psy findings available appletion of cause of 22 No
/Ita	cian: ertific actor.	Be	25. Was case referred to medical examiner?	(1)					Death (Check only o			
0	Physic this cral din	. To	1 Tyes 22No 27. Manner of Death		☐ Inpatient 2 ☐ te of Injury	ER/Outpatier 28b. Time of		4. Nursi	ing Home 5 Resid			"
Division of	ending sath. or: After he fune	ation	1 Naturaf 5 ☐ Pending 2 ☐ Accident investiga	(Mation	onth, Day Yeer)	Injury	Wor	k? Yes 2□No		- Injury South		
Ž Ž	al or Att s after d il Diract ed in by t	Certification:	3 Suicide 6 Could no determine	288, P18	ice of Injury - At ho ilding, etc. <i>(Specif</i>	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	itreet and Numb n, State)	per or Rura	i Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funaral Diractor: After this certifical completely filled in by the funaral director.	edical (29a. Certifier (Check only one) Certifying Certifying Certifying	xeminer: On the	the best of my kno basis of examina anner stated.	owledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date and p pinion, death	olace, and due to the o occurred at the time, o	cause(s) and ma date and place,	an <i>n</i> er as st and due to	ated. the cause(s)
,	To th Withir To th	Me	29b. Signature and title of certifier	Kolo	Zuy 1	4. P.	29c. Licens D 3.		_	29d. Date signe		Day, Year) 2004
	1		30. Name and address of person w	no completed ca	ause of death (Item	23a) (Type,			POCKVILL	E, MI	20	852
8	Sta Registr		31. Date filed (Month, Day, Year) OCT 19	2004	. Registrar's Signa	iture 49	Sporks				-	

WILLIAM HICKOX UNK 04-339 PleaseType or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-06799 State of Maryland / Department of Health and Mental Hygiene dl 34796 State Registrar Unpend Item 23a,27,28a-f perCertificate of Death 2 G337 11-9-046 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Charles Hickox October 20. 2004 6:06 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Agnes Hospital | Baltinole | If Under 14 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 11, 1961 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1₩M 2□F 42 Yrs 225-04-4272 Cyprus Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show itam 27 is markad othar than "natural", or items 23a or 28a-f show othar traumatic evant, If a Mudical Examinar must be notified at 1 X Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 108 East 6th Street 21701 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 212 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hyglene. Important: If itam 27 is marked other than "ne any injury or other traumatic event, If a Mudic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene Fremont Hickox Mildred Lee Stephenson ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 108 East 6th Street; Frederick, MD 21701 Daniel Hickox / Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 27, 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Resthaven Crematory 2004 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland 21. Signature of Funeral Service Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Ant. Enter the see se. o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, clock, or heart failurs. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Narcotic and alcohol intoxication disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown 9 Unknown signed by det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ should be 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an has page 2 autopsy performed certificate Yes 2□ No or Attanding Physician: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2X EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 XYes 2 No this 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: : After 1 Natural 5 Pending death. Unknown ^M 1 ☐ Yes 2 X No Unknown investigation 10-20-04 2 Accident completely filled in by the Diractor: 6 X Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Frederick Ave. & 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide after Hilton St., Baltimore, MD Auto within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RIPPLEFOR OCME October 21, 2004 30. Name and appress of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

Da

31. Date filed (Month, Day, Year)

LOCK

OCT

2 8 2004

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland

oaks

			For State Registrar	State of	Maryland	/ Depa	artment of H	ealth an Death	id Men	tal Hygiei Reg.		4 3	3479	37
Y			1. Decedent's Name (First, Middle, La	ist)						Date of Death		ear	3. Time of De	eath
Н	Physici /Medic		LETA	IVA HE	EVNER						L4, 200		1:10	A M
}	Examin		4a. Facility Name (If not institution, gir	e street and num	ber)		4b. City, Town, or	Location of D	Death		4c. County of I	Death		
			Frederick Memori 5. Social Security Number 6.		tal 7. Age (In yrs. las	t highdayl	Frederi		Hrs a r	Date of Birth	Freder		(0)-1	
	Funeral Director		-	1 M 2 XF	84	Yrs.	Months Days			Month, Day, Ye	1920	Country	e (State or F	oreign
	D		Usual Residence of Decedent							- 7,	1,720			
	srylan	_	10a. State 10b. County		10c. City, 1	Town or Lo						10d	Inside City L	
	8e-f	Director	Maryland Frede	rick			Union Br	idge					1 ☐ Yes 2	
	death with the Maryland ms 23e or 28e-f show		10e. Street and Number 12702 Molasses	Dal			10f. Zip Code	791		10g.	Citizen of Wha	,		
	leath	Funeral	11. Marital Status		dent Ever in U.S.	13.			? (Specify	Yes or No-	14. Race -	American		
9	or Item	Fun	1 ☐ Never Married 2 Married	Armed Ford	ces? 2 🔀 No		Was Decedent of Hi If Yes, specify Cuba		uerto Ricai	n, etc.)		White, etc		
2-0036	hours after tural, or Ite	d by	3 Widowed 4 Divorced	If Yes, Give Year or Da	tes:		1 ☐ Yes 2 No	Specify:			Specify:	Whit	e	
5	natu	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		(Give	dent's Usual Occupa kind of work done of	uring most of	working	16b	. Kind of Busin	ess/Indus	stry	
12	filed within 72 Hygiene. other then *net	duic	Elementary/Secondary (0-12)	College (1-	4or 5+)	iite.	DO NOT use retired, homemak				own h	ome		
Maryland 21	be filed within 72 hours after death with the Marylan tal Hygiene d other than "natural", or Items 23e or 28e-f show event, it is Madical Examiner must be militiad at	e Cc	17. Father's Name (First, Middle, Las	t)					Name (Fire	st, Middle, Maid				
au		To Be	Herby Cliffor	d Eyler				L	inda	Iva Bos	tion			
ary	de primit	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a					te, Zip Co	ode)	
	1 and 2 Health a tem 27 ls		Alice Hevner/ da	ughter			2 Molasse	s Rd.		on Brid	lge, MD	217	91	
altimore,	of He of He or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 (Removal from S		e of Dispo letery, crei	sition (Name of matory or other place	9)	Date	20c.	Location - Cit	y or Town	, State	
Ě	permit. Pages Department of I Importent: If ite eny injury or of		*4 □ Donation 5 □ Other (Spec.	ify)	John:	svill	e Cemeter	y 10	/17/2	004 Jo	hnsvil.	le.	4D	
Ball	permit. Departr Importe eny inje		21. Signature of Funeral Service Lice	RSOO / /a 1	bler	22	2. Name and Addres	s of Facility	Hartz	ler Fun	eral H	ome		
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	Pnysician /Medical		disease or condition resulting in death)	d	tastatic or as a consequer		east Co	ince				7	Yea	213
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9 X	death certifi e attending p od for use as	Physician/Me	IF FEMALE:	23c. If yes, outc	ome of pregnanc	у					23d. Date of	f delivery		
Вох	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th 2 Fetal de int at time of deat	eath 3	Ectopic pregnancy Other (specify)				Month	Da	ay Yea	ır
o.	t the d by the ached	hysi	9 Unknown	9□ Unknov			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							
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rd	w require been sig should b								_	1 🗆 Yes	2 □No 3 □] Probabi	y 4 ⊟Unki	nown
Records,	law re as be 2 sho	ompieted							_ [24a. Was an autopsy	24b. Wer	e autopsy	findings ava letion of caus	ulable
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hoonital:			Othe		Death (Ch	eck only one)				
0	Phys this al di	To To	1 Yes 2 No 27. Manner of Death	Hospital: 1 In	1	VOutpatier 3b. Time o		4 🗆 Nursin		5 Residence		Specify)		
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Division	il or Attending after death. Director: After d in by the fune	fica	3 Suicide 6 Could not	be 28e. Place of	of Injury - At home	e, farm, str	eet, factory, office		28f. L	ocation (Street	and Number o	r Rural R	out e Numbe r,	
ă	el or safter	Certification:	4 Homicide	buildin	g, etc. (Specify)				,	City or Town, St.	ate)			
	ospitel hours a unerel I		29a. Certifier 1 Certifying P	hysicien: To the h	pest of my knowle	edge, deati	n occurred at the tim	e, date and pl	lace, and d	lue to the cause	(s) and manne	r as state	id.	
	To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	fedical	one)	and manne	er stated.		00 11							
	To To con	Σ	29b. Signature and title of certifier	1 Mm	MD		29c. License	number	4	29d. I	oate signed (M	onth, Day	(Year)	
7	m &			20/10		7	1 2 7	010	,		0 / . /			
	I.) &		30. Name and address of person who Ellamy Eskan			3a) (Type, 5 7 ft	Print) Street	- Fre	deric	K, M	D 21	70(
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatur	е								
	Registr		OCT 18	3 2004	Eleen.	J.	Soule							

State of Maryland / Department of Health and Mental Hygien 200 [] 34798 Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** Edna E. Hall October 2004 10:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Glen Burnie An

7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 7561 East Howard Anne Arundel Road 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1□ M 21 F 70 Yrs. Director Oct. 13 1934 Maryland 219-26-1694 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral', or Items 23a or 28a-f show Examiner must be notified at 1 TYes 2 No Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7561 East Howard Road 21060 USA death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: **Black** Specify: þ 3 Widowed 4 Divorced "natural" al Hygiene. I other than "natura vent, the Modical E Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Housewife None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental F Be Randall Coates Irene Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 2 1 1 1 7 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health an Importent: If item 27 Is any injury or other trau QDGs. Michele Hall -Davis (daughter) 11 Kentbury Ct. Owings Mills, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland Veteran 20a. Method of Disposition 20c. Location - City or Town, State t® Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery 10/19/04 LCrowns

22 Name and Address of Facility
Wm. Reese & Sons Mortuary, P

821 West St. Annapolis, Md. 10/19/04 Crownsville, Md. 21. Signature of Funeral Service Licensee Jarry A. Leen Moc 483 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) east syears **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed and Due to (or as a consequence of): physician a s the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 ☐No 3 ☐ Probably 4 ☐Unknown has been si e 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: After Jospiter C. 24 hours after de. rerel Director: Atte 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D39505 October 18, 2004 I prive, Glen Burnie, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSbit 305 Man dhish ma 31. Date filed (Month, Day, Year) OCT 1 8 2004 32. Registrar's Signature Registrar

			For Stata Registrar	State of	f Maryland / Dep <i>Ce</i>	artment e ertificate			Mental Hy	, ,	2004	34799
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	/Medic	al	Oney Law Ha 4a. Facility Name (If not institution, give	irston	nber)	4b. City. To	wn, or Location	on of Death	Oct.		17 200 c. County of Deat	
	Examili	lei	Union Hospital		,	Elkt					Cecil	
	Funeral		Social Security Number 6. S.	x □M 212 F	7. Age (In yrs. last birthda) Yrs.) If Under 1		er 24 Hrs. s Min.	8. Date of B (Month, D	ay, Yea	r) 9. Birt	hplace (State or Foreign
ш	Director		227-24-3031 Usual Residence of Decedent	7	93 ***				08/14	4/19	911 Vir	ginia
	ahow d at	_	10a. State 10b. County		10c. City, Town or I	ocation						10d. Inside City Limits
	the Ma	ecto	DE New Cas	tle	Wilmin					40. 0	*** ****	1 X Yes 2 □ No
	Mith 1	Funeral Director	112 Connell St	reet		10f. Zip Co				US	itizen of What Co	untry?
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36	s after	by Fu	1 Never Married 2 Married	1 ☐ Yes If Yes, Giv	2 X No	1 ☐ Yes 2			nicari, etc.)		Specify: D.1	
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ore	of of it it		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □		20b. Place of Disp cemetery, cri Gracela	amatory or other	r nlace)		Date /23/04		Location - City or	
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α.	\$ 8 B		Part II. Other significant conditions of	ontributing to de	eath but not resulting in the	underlying caus	se given in Pai	t I.	23e. Did	tobacco	use contribute to	the cause of death?
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	a Hospitel or Attand 24 hours after death a Funaral Diractor: / etely filled in by the f		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sician: To the	best of my knowledge, dea	th occurred at t	he time, date	and place,	and due to the	cause(s	s) and manner as	stated.
	To tha Hos within 24 h To tha Fur completely	Medical	one)	and manr	sis of examination and/or i per stated.				ed at the time,			
	Vitt	~2	29b. Signature and the of certifier	5 01			icense numbe			29d. Da	ate signed (Month	, Day, Year)
7			30. Name and address of person who of		e of death (Item 23a) (Type	. Print)	$\alpha \alpha \beta \beta$)dd		- 1	017.04	
	5		S.S SACHIDE	EV MD	118Noet	2 St 8	rute 31	B, E	= 666	и /	10-17.04 ND 217.	2/
	Sta Registr	_	31. Date filed (Month, Day, Year)	32. B	egistrar's Signature	land !						د.

State of Maryland / Department of Health and Mental Hygiene 34800 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2004 Gloria E. Irizarry-Rogers **October** 18 2:30 A M /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 8701 Adventure Avenue Walkersville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. August 28, 1948 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗙 F 584-26-3943 Director Puerto Rico Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location. 10d. Inside City Limits 28a-1 ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ▼No Director Maryland Frederick Walkersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 21793 or Items 23a 8701 Adventure Avenue U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Š 1 ▼ Yes 2 No Specify: Puerto Rican Specify: White 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filed wi trent of Health and Mental Hygien tant: If tem 27 is marked other th ijury or other fraumatic event, Its Payroll Clerk Clothing Manufacturer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ Santiago Irizarry Gumersinda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael J. Rogers/Husband 8701 Adventure Avenue, Walkersville, Maryland, 21793 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Porta Coeli Cemetery 10/23/2004 San German, Puerto Rico 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 106 East Church Street Mª Million Keeney and Basford P.A. Funeral Home Frederick, MD, 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition METHSTATIC **Physician** YEARS /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician a Due to (or as a consequence of) Box 68760 Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown á ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe page certificate 1 Yes No or Attending Physician: 25. Was case referred to medical examiner? al director. Be 28. Place of Death Check only one Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No Director: / 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 🗌 Homicide hours after within 24 hours at To the Funeral D completely filled is the Hospital Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Chack shift one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31761 Coand 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 501 W. SEVENTH ST. FREDERICK MD CONNOR MA 2004 Signature 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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istrar NCT 1 9 2004 Alaska A Appell		31	I. Date filed (Mo	nth, Day, Year)	nn.	32. F	Registrar's	s Signal	ture	-							/				

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1 - For State Registra 2. Date of Death Month I. Decedent's Name (First, Middle, Last) Year **Physician** Pitts October 14, 2004 4:40 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Millennium Health Care Center Prince George Ft. Washington

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Ft. 8. Date of Birth (Month, Day, Mar. 28, 9. Birthplace (State or Foreign Country) North Carolina 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 219-10-3019 80 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ital Modical Examinating mant be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Director Maryland Prince George Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9811 Green Apple Turn 20772 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∰No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 XWidowed 4 ☐ Divorced Black Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietary Aide Medical Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pitts Henry Mamie Cofield 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lena Cuffy 9811 Green Apple Turn Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crestview Memorial Cem. 10/20/04 Roanoke Rapids, NC 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville,Md. 21. Signature of Funeral Service Licensee welle 20747 08 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last is a consequence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 1 No 3 Probably 4 Unknown 1 TYes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed res 2 No 1 Yes the Hospital or Attanding Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After this 27. Manher of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 🗹 Natural 5 Pending 1 🗌 Yes 2 🗌 No investigation 24 hours after death. 2 Accident the 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To tha I 29b. Signature and the of certifier 29¢. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laxmi N. Berwa, M.D. 7700 Old Branch AVe. Suite C-101; Clinton, Md. 31. Date filed (Month, Day, Year) State OCT 1 9 2004 Registrar DHMH 17 Rev 1/2001

ORIGINAL

			1 - State of Maryland / Departm	nent of He cate of D	alth and Me eath	ental Hygie	2004	34803
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
н	Physicia /Medic		Theodore Jaffe				16, 2004	7:30 P M
>	Examin		4a. Facility Name (If not institution, give street and number) 4b.	City, Town, or Lo	ocation of Death		4c. County of Death	1
				ethesda			Montgome	ry
	Funeral		J. Social Security Humber		f Under 24 Hrs. Hours Min.	3. Date of Birth (Month, Day, Y Aug 24,	ear) 9. Birth	place (State or Foreign untry)
	Director		036-20-4723			Aug 24,	1910 Rho	dé Island
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	ก				10d. Inside City Limits
	Mary f ehc	ō	Florida Palm Beach S. Palm Bea	ch				1 X Yes 2 ☐ No
	the 28a	Director		Of. Zip Code		10g	. Citizen of What Co	untry?
	3a or		3520 S. Ocean Blvd., #406F	33480		Ţ	Jnited Sta	tes
	ms 2	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was I	Decedent of Hisp	anic Origin? (Spec Mexican, Puerto R	ify Yes or No-	14. Race - Amer	
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Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other then "netural", or items 23a or 28a-f show artic event. The Medical Esam and must be notitied at	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1944				W	hite
2	72 h	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done dur IOT use retired)	on ing most of working	9 16	b. Kind of Business/l	ndustry
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and	ntal led of	Be c	David Jaffe		Ette		Cimpkin	
2	should nd Me mark matic	ဥ		idress (Street and			City or Town, State, Z	ip Code)
<u>s</u>	treu		Irving Jaffe, brother 5225 Po	oks Hill	Road, #	401S Bet	hesda, MD	20814
ē,	Hea Hea Item		20a. Method of Disposition 20b. Place of Disposition		Da		c. Location - City or	
9	Page ento		1 X Burial 2 □ Cremation 3 X Removal from State '4 □ Donation 5 □ Other (Specify) King David		n. 10/19/	2004 F	alls Churc	ch. VA
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural; or Items 23a or 28a-f show among nighty or other treumatic event, the Medical Examination in the notified at once.						ion, Inc.	
m	Person		Haruth The 109	l Rockvi	ille Pike	, Rockvi	11e, MD 2	0852
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	/Medical		resulting in death) a. Due to (or as a consequence of):					
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9 X	The law requires that the death certificate has been signed by the attending lagge 2 should be detached for use as	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy				23d. Date of deli	verv
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n of			27. Manner of Death 1 X Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury Injury	28c. Injury a Work?	t 2	3d. Describe how	injury occurred	
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation		s 2 No			
Division	ter direct	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office	2	City or Town,	et and Number or Ru State)	ral Houte Number,
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu		200 Contilior 18 Contibute Character To the	numad at the ti-	data and nine	ad dup to the	en(e) and	stated
	Hosi 24 ho Fune fely f	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only 2 Medical Examiner: On the basis of examination and/or investigned one) 20 Medical Examiner: On the basis of examination and/or investigned one)	gation, in my opir	ion, death occurre	d at the time, date	se(s) and manner as and place, and due	to the cause(s)
	o the ithin (Me	29b. Signature and title of certifier /	29c. License r	number	290	I. Date signed (Month	n, Day, Year)
•	⊢≯⊢ŏ		1/1-12 m	DOO.	11921		Octobor 10	2004
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print		1761		October 18	, 2007
	*		John Galotto, M.D., 5225 Pooks Hill Ro		Bethesd	a, MD 2	0814	
	St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Sparker				
	Regist	rar	OCT 19 2004 April 19	yours				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 0 0 4 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** KRONER 2004 BERNARD OCT 7 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 5ALISBORD WICOMICO DEERS HEAD HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Hours | Min. | 10 / 29 / 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 ☐ F Maryland Director 219-16-5914 80 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ai', or items 23a or 28a-f si Examiner must be notified 1 ☐ Yes 2√2 No Director Maryland Wicomico Hebron 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21830 USA 6813 Quantico Rd. Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Army 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: þ Specify: white Year or Dates: WW II 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Soap Production Machinist 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) end Mental Pearl M. Brothers Charles A. Kepner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) of Health Dorothy Kepner/wife 6813 Quantico Rd., Hebron, MD 21830 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date important: if it any injury or c once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory 10/18/04Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Lice see "Holloway runeral Home Professional Assoc 501 Snow Hill Rd., Salisbury, MD 21804 23 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HEART FAILURE Examiner Due to (or as a consequence of): Examine or Attending Physician: The law requires thet the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, mellitus attending physicien for use as the bune DIABETES Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown CORDORRRY DISEASE ARTERIAL Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 → Inpatient 2 □ ER/Outpatient 3 □ DOA ဠ 1 Yes 2 No this funerei 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No deeth. ector: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) D33905 Dukery mo in Oct 18, 2004 30. Name and accress of person who completed cause of deeth (Item 23a) (Type, Print) SALISBURY MD Z(80270)& nlawy MD CMD 10,2018 VIRGINIA 31. Date filed (Month, Day, Yeer) 32. Registrar's Signature

Registrar

State

OCT 1 9 2004

DHMH 16 Rev 6/95

				1- State of Maryland / Department of Health and Certificate of Death	d Mental	Hygie _{Reg.}	6111) 4	34805
		0.0		1. Decedent's Name (First, Middle, Last)	2. Date of		Day	Year ,	3. Time of Death
		Physici /Medic		Bettyanne Laura Kelly	00	t.	15 2	004	1420 M
		Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De	eath		4c. County	of Death	
				VENINSULA REGIONAL MEdical CENTER SALISBURY	Mcl.		Wi	comi	w
		Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F Months Days Hours M	lin. (Month	i, Day, Ye		9. Birthpl Coun	lace (State or Foreign try)
		Director		214-46-3941 - 58	07/2	0/19	946		yland
		and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10	0d. Inside City Limits
		Marylan f ehow led at	ö	Maryland Wicomico Delmar					1 ☐ Yes 2X No
1		the t	Director	Maryland Wicomico Delmar 10e. Street and Number 10f. Zip Code		10a	Citizen of V	What Coun	trv?
4		with a or						Trial Ocum	
-394		eath	Funerai	8485 North Prong Lane 21875 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	(Specify Yes o		USA 14 Bac	e - America	an Indian
1	40	ter d	In In	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 12. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	erto Rican, etc	.)		ck, White, e	
74	33	urs al	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 No Specify:			Specify	v: w]	hite
	5-0036	tiled within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Itama 23a or 28e-f ehow shi, the Madical Examinar must be motified at	ted	15. Decedent's Education 16a. Decedent's Usual Occupation		16b	o. Kind of Bu	usiness/Ind	lustry
214	218	hin 7	pje	(Specify only highest grade completed) (Give kind of work done during most of the life. DO NOT use retired) (Give kind of work done during most of the life. DO NOT use retired)	working	1			
	21	filed withi Hygiene. othar than	Completed	12 - Insurance Agent			Insu	ranc	e
7	pu	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Itam 27 is marked other then "netural", or Itame 23e or 28e-f ehov other traumetic event, the Medical Examiner must be notified at	Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Last)	Name (First, Mi	ddle, Maid	den Suman	10)	
Bety A. Kelly	Baltimore, Maryland	should be and Mental is markad c	To 1	Base Shockley Haze	l Whi	te			
F	an	2 sho and I is me		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route N	umber, Ci	ity or Town,	State, Zip	Code)
B	Σ	of Health of Health Itam 27 i		Donald L. Kelly/husband 8485 N. Prong Lan	ne, De	lmar	MD	218	75
13	or c			20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State	Date		. Location -		
Et	Ĕ	Pages nent of It ant: If Its ary or of		Tabulat 2 Communion 3 Themoval from State	0/19/0	4	Sali	shur	v MD
Q	alt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Ligensee 22. Name and Address of Facility HOLLOWAY Funeral	ral Un	ma F) m n f n		y , 110
	8	9 9 E 8 9		Coll (Alues E) 501 Snow Hill	Rd S	me r alie	rore	SSIO	nal Asso
				23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line.	liac or respirato	ry arrest,	·wur y	721	Approximate Interval Between
		Physician		I the state of the	nus				Onset and Death
		/Medical		resulting in death) Due to (or as a consequence of):	nan	-			5 yrs
		Examiner		Commentative that are different					
		- +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
		cuted nd ransi	Examiner	that initiated events C.					
	oʻ	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):					
	8760,	cate be executed physician and the burial-transit	Physician/Medicai	d					
	99		Med	IF FEMALE:					
	Box 68	eath certific attending pl	an/I	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy				te of deliver	•
	Э.	ne dea the att	sici	1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		_	Moi	ntn i	Day Year
	P.O.	that the di ed by the detached	hy	9 Unknown					
		ires thai signed t d be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					e cause of death?
	D.C	w requir been s should	ted		- 1	Yes	2∐No	3 ☐ Proba	ably 4 Unknown
	ecc	law r as be 2 sh	ompleted			Vas an lutopsy	24b. \	Vere autop	sy findings available apletion of cause of
	Œ.	hyaicien: The law nis certificate has I I director, page 2 s	Com		1 U Y	erformed	1? 0	death?	2 No
	2	ien: rtifica	Be C	25. Was case referred to medical examiner?	eath (Check or				
	\	nyaic is ce	To E	Hospital: /*	gHome 5□F	Residence	e 6 □Oth	er (Specify))
	0	ding Phy h. After thi funeral (27. Manner of Death 1	28d. Descr	ibe how in	njury occurr	ed	
	Ö	tendir death. tor: Al the fu	atic	2 Accident investigation M 1 Yes 2 No					
	Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	ertification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location City or	on (Street Town, St	and Numbi	er or Rural	Route Number,
		ital o	Cer						
		To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and plated and plate the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate the control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plate the control of the basis of examination and/or investigation.	ace, and due to ocurred at the ti	the cause me, date a	∍(s) and ma and place, a	nner as sta and due to	ited. the cause(s)
		ithin 2 o the	Med	one) and manner stated. 29b. Signature and titlg of certifier 29c. License number		29d.	Date signed	d (Month, D	Jav. Year)
		F ≥ F Ø		D 205		11	0/10)	04	
				30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				-	
η	DQ			50 SANN W CRASSI 195 E. (AMNVIL ST	SALI	(V)	1111	M	V)
'		Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	0 1/01	- 10 V	1109	7/1	
		Registr		OCT 1 9 2004 Some & sparts					

Certificate of Death

Rockville

Days

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Hours

KING

7. Age (In yrs. last birthday)

87

4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Home 1235 Potomac Valley Road

6. Sex

1 □ M 2 → F

Reg. No. 2. Date of Death 3. Time of Death Month Year 10 15 2004 10:10^M 4c. County of Death Montgomery 8. Date of Birth (Month, Day.) Birthplace (State or Foreign Country) T917 Virginia 10d. fnside City Limits 1 ☐ Yes 2X No 10g. Citizen of What Country? U.S.A. 14. Race - American Indian, Black, White, etc. Specify: Black 16b. Kind of Business/Industry Retired Federal Government Rogers Jones 20c. Location - City or Town, State Approximate Interval Between Onset and Death 23d. Date of delivery Month Day 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 25ZN0 1 Yes 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) October 15, 2004 Mahmoud Doski, M.D. 1299 Lamberdon Road, Silver Spring, Maryland 20902

34806

State Registrar 1 - For State Registrer

10a. State

Physician

/Medical

Examiner

Funeral

Director

1. Decedent's Name (First, Middle, Last)

10b. County

J.M

31. Date filed (Month, Day, Year) OCT 1 9 2004

30. Name and address of person who completed cause of death (ftem 23a) (Type, Print)

ELEANOR

5. Social Security Number

118 20 4420

Usual Residence of Decedent

. Registrar's Signature

D0061959

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 001 34807 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 16, VIVIAN MAE KEEFER October 2004 7:45 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Annapolis
If Under 1 Year | If Under 24 Hrs Annapolitan Assisted Living Anne Arundel 8. Date of Birth (Month, Day, Year)
Oct. 29, 19 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1 □ M 2 🗓 F Months Days Illinois Director 90 1913 215-76-4128 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Completed by Funeral Director Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 322 Chalet Drive 21108 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Housewife Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John K. Turner Grace E. Ritchey 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr 2006. Robert L. Keefer Son 322 Chalet Drive, Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/19/2004 Metropolitan Crematory Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 2/2011 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rana **Physician** -auluv disease or condition resulting in death) /Medical Due to (or as a consequence of) schemic Examiner Ivansien Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an perform 1 Yes 2 X No 25. Was case referred to medical examiner? Assisted Living 26. Place of Death (Check only one) Hospital: Cther: 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 1 🗌 Yes 2X No 3 DOA 2 1 Inpatient 2 ER/Outpatient 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H0044184 take RIDO

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DHMH 17 Rev 1/2001

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Show

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certificate be executed

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Division of Vital Records,

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Hospital or Attending

death.

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24 hours a

To the within 2

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signed t

marked other treumatic event,

State Registrar

OCT 1 9 2004

31. Date filed (Month, Day, Year)

Marsha Blakeslee, DO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

479 Jumpers Hole Road, Severna Park, MD 21146-1600

State of Maryland / Department of Health and Mental Hygien 2001. 34808 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 14, Stuart Ronald Krasner 2004 3:40 A. M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 26, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Birthplace (State or Foreign Country) **X** M 2□ F Months Days 1930 74 Director 578-36-9537 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23c or 28e-f show 1 XYes 2 No Potomac Funeral Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 7837 Muirfield Court U. S. A. 12. Was Decedent Ever in U.S. 13 Ammed Forces? 1 Aves 2 □ No Airforce 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
ent: If item 27 Is marked other then "neturel", or Itel ury grother treumatic event, Ire Medical Examination 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Korean 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Retailer Ladies Garments 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rega Bragman Aaron Krasner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugenia I. Krasner - Wife 7837 Muirfield Court, Potomac, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ★ Removal from State 20c. Location - City or Town, State injury or permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 10/15/2004 Falls Church, Virginia National Crematory 21. Signature of Funeral Service Edward Sage I Funeral Direction, Inc. Donald (- 1091 Rockville Pike, Rockville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Advanced Follicular Lymphona disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, backing to firm offars cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of: Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 ☐ Yes 2√☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 autopsy performed? certificate 2∏No 1 ☐ Yes 2 No 1 Yes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: P 1 ☐ Yes 2 💢 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Certification: After Injury at Work? Injury 1 XNatural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the To the 29b. Signature a 29d. Date signed (Month, Day, Year) D41218 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Harrison, MD 6001 Muncaster Mill Road, Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature 19 2004 OCT Registrar

State of Maryland / Department of Health and Mental Hygiene 001

	1	For State Registrar		Olaic o	1 10101	y land /		tificat	e of l	Death		R	eg. No	ZUL	J 4	34809
Physiciar		1. Decedent's Name (First, Mic Tony		lenda								2. Date of Dea Month October		y oc	Year	3. Time of Death
/Medica	1 -	~						4b City	Tours	Location		October	7		of Deeth	2:20 P M
Examine	r '	le. Fecility Name (If not institut Charlotte				Home					Hall	L	40	,	. Ma	ry's
Funeral Director		5. Social Security Number 372–28–5846	6. Sex			(In yrs. last b	irthday) Yrs.	If Under Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day July 29	Year	915	9. Birthp Cour	lace (State or Foreign liv) Unknown
and *	<u> </u>	Usuel Residence of Decedent 10a. State 10b. Cour	ty			10c. City, To	wn or Lo	cation	-						1	0d. Inside City Limits
sa-f aho		MD St.	Mar	y's		Char	lott	e Ha					0- 0:	***** - 6 1	What Care	1 ☐ Yes 2 🖁 No
ith with th	runeral Director	10e. Street and Number 29449 Charle								0622			τ	Jnite	What Cour	ates
Urs a	2	11. Marital Status 1 Never Mamed 2 M 3 Widowed 4 Divorce	arried	2. Was Dec Armed Fo 1 X Yes If Yes, Gi Year or D	orces? 2 ∐ No ve	1939 1955				ispanic Or in, Mexica Specify:		ecify Yes or No- Rican, etc.)			k, White,	an Indian, etc. ite
5-0	ered	15. Deced (Specify only hig	ent's Educ	ation completed)		16	/Gin	dent's Usu kind of wo	ark dans	during mos	st of worki	ng	16b. K	Kind of Bu	siness/In	dustry
21215-0036 od within 72 hours alt giene. ar than "natural", or if the Medical Exam	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	III e.	DO NOT	Unkn	own			Fe	edera	al Go	vernment
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Manate.	ge	17. Father's Name (First, Midd	le, Last)	Unkı	nown					18. Moth	er's Name	(First, Middle, Unl	Maider CNO V		10)	
Maryland ad 2 should be file tith and Mental Hy 27 is marked oth	0	19a. Informant's Name/Relation Alexander Car			iend							ton, MD		or Town, 0735	State, Zip	Code)
s 1 and 1 Healt	-	20a. Method of Disposition				20b Place	of Dispo	sition (Na	me of	(e)		Dete	20c. L	ocation -	City or To	own, State
Page Page nent o		1 Burial 2 □ Crematic 1 □ Donation 5 □ Other		emoval from	State	Mary1	and Ceme	Vete tery	rans		Octol	ber 21	Che	elte:	nham,	MD
Baltimore, permit. Pages 1 a Department of Hes important: If item any injury or othe		21. Signature of Funeral Servi	ce License	n/ n	:0/	7/1				ss of Facil	Lec	e Funera	a1 1	Home	, Inc	Mn 20735
m 40544	-	23a, Pert 1, Enter the disease,	or compli	cations that	caused t	he death. Do								CII	цсоц,	MD 20735 Approximate
Physician		shock, or heart failure. L Immediate Cause (Final	ist only on	e cause on	each line),				entia						Interval Between Onset and Death
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Examiner	_	Sequentially list conditions, if any, leading to immediate	ь)	(25.22.2	consequence	o of\:									
ted nsit	Examiner	Cause (Disease or injury	⊀	Due to	(Or as a	consequence	e Oi).									
		that initiated events resulting in death) Last	C	Due to	(or as a	consequence	e of):									 .
68760, rificate be executed g physicien and as the burial-transit	Ical			l												
ords, P.O. Box 66 requires that the death certific een signed by the attending p hould be detached for use as 1	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2		birth 2 nant at t	f pregnancy Eetal dea ime of death		⊒Ectopic ρ ⊒ Other (s		′					te of delive	ery Day Year
	2	Part II. Other significant cond		-		-		nderlying	cause giv	en in Part	l.					ne cause of death?
v requir	Completed	Atrial Fi	bril	lation								24a. Was a				
Il Rec The law ate has b	d l	Anemia										autop			orior to co death? I 🔲 Yes	psy findings available impletion of cause of
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of Vita Physician: this certific	ှ	1 Yes 2 No	F		Inpatien			nt 3 D		4 (= 14		me 5 Resid				у)
Jn C	ion	27. Manner of Death 1 ▲Natural 5 □ Per	iding estigation	28a. Date (Mor	of Injury	Year) 28b	. Time o	M	28c. Injur Wor	yat k? Yes 2.⊑		28d. Describe h	ow inju	iry occur	ed	
Division of Vital Records, to Attending Physician: The law requirest after death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Certification:	3 Suicide 6 □ Coi	ald not be ermined	28e. Plac build	e of Injud ing, etc.	ry - At home, (Specify)	farm, st					28f. Location (S City or Tow			er or Rura	al Route Number,
Hospita 4 hours Funeral	edical Ce			ner: On the I		examination a						and due to the deed at the time, o				
To the within 2 To the complet	Me	29b. Signature and title of cen	ifier	4110				29	c. Licens	e number			29d. Da	ate signe	d (Month,	Day, Year)
F \$ F 0		1/2	J. J.	2		M.D			Ι	0052	097			10/1	4/200	04
5000		30. Name and address of pers							n :	T	L	dol- M	2	0670		
DD 10%		Janelle I 31. Date filed (Month, Day, Ye				lospitar's Signature	al R	oad	rrii	ice F	reder	ick, MD		20678		····
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			For State	State of M		epartment of Heali			31.810
			Registrar 1. Decedent's Name (First, Mid	idle Last)		Jeruncale of Dea	2. Date of I	Reg. No.	04010
	Physic		71.7	-cal Va	stigar	· Tr	Month	Day Year	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institut	tion, give street and number		4b. City, Town, or Local	tion of Death	4c. County of Deat	<u> </u>
	LAUITIII		Sinai L	tospital .	(Ballino	211	ove Cris	of Board, or Board	,
i	Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. last birth	day) If Under 1 Year If Un	nder 24 Hrs. 8. Date of B	Birth 9. Birth	nplace (State or Foreign untry)
	Director		218-34-1418	1 □ M 2 □ F	66Y	rs. Months Days Hou		29 1937	MD MD
7	and		Usual Residence of Decedent 10a. State 10b. Cour	nty	10c. City, Town	or Location			10d. Inside City Limits
/ 3	Maryi	ō	MID Ca	rroll		inster			1 ☐ Yes 2 No
5	death with the Maryland ma 23a or 28a-f ehow In the Lear chilled at	by Funeral Director	10e. Street and Number			10f. Zip Code		10g. Citizen of What Co	
30	h with	ie D	2121 Coon Clu	b Road		21157		USA	,.
-	after death w	ner	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.S.	13. Was Decedent of Hispanie If Yes, specify Cuban, Me	c Origin? (Specify Yes or I	No- 14. Race - Ame	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	or lite	F	1 ☐ Never Married 2 🔀 M	arried 1 Tes Sive		_	ecify:		
2	72 hours "natural",	d b	3 Widowed 4 Divorc	ed Year or Dates				Specify Whi t	
(14	within 72 hours after ene. then "natural", or Ita	Completed	(Specify only high	ent's Education hest grade completed)		Decedent's Usual Occupation Give kind of work done during life. DO NOT use retired)	most of working	16b. Kind of Business/I	ndustry
3	filed within Hygiene. ther then	E O	Elementary/Secondary (0-12	College (1-4or	5+)	Administration		Social Sec	naci tr
% =	other	Be C	17. Father's Name (First, Middle	e, Last)			Mother's Name (First, Midd		ur i cy
	y carried to a Mental Mental Carried C	To B	John Joseph	Kasigar Sr			Margaret Lar	ngdon	
Marylan	inc, intally lated a Late 100000 s 1 and 2 should be filed within 72 hours after de if Heelih and Mental Hygiene. Itam 27 is marked other then "natural", or Itam other traumatic event, the Meulcal Exprinted.		19a. Informant's Name/Relatio	nship (Type, Print)	19b. I	Mailing Address (Street and No	umber or Rural Route Nurr	ber, City or Town, State, Z	ip Code)
> -	s 1 and 2 and 27 ltam 27 other tree		Helen Kastiga	r/wife	2	121 Coon Club			21157
3	Pages 1 nent of H int: If Ita		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio	n 3 🗌 Removal from State	cemetery,	Disposition (Name of crematory or other place)	Date	20c. Location - City or 1	own, State
A Sulfimore	it. Pa		* 4 □ Donation 5 □ Other 21. Signature of Funeral Seguin		St. John	n Cemetery	10/21/2004	Westminste	
, a	Dalfillion permit. Pages Department of Important: If It any Injury or o		21. Signature of Purioral Service	- Licensee		22 Name and Address of F Pritts Funer	tal Home and	Chapel, P.A.	21157
			23a. Part1. Enter the disease,	or complications that cause	d the death. Do no	412 Washingt	on Road Wes	tminster M	Approximate
	Physician		Immediate Cause (Final	ist only one cause on each	line.		1.		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or a	s a consequence of	or c Cov	nplication	DV 2	21days
	Examiner		Partial talls for explicit			//	1 11 11	1 - 2	0 0
	pe #s	Examiner	Eequeritially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequence of	7.77	ADDROUGH BY MEDICAL E	ARINER	
	and I-trans	xam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a)	s a consequence of		APPROVED BY MEDICAL EX	COMINER	
8760	rate be executed only sicien and the burial-transit			250 10 (6) 4.	2 d 00/130420/100 01,	•			
789	tificate ng phys as the	edicai		d					
2	leath certifications attending postering poste	Z	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome				23d. Date of deliv	verv
ď	that the death	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		2 ☐ Fetal death at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
0	at the 1 by #	Phys	9 🗆 Unknown						
U	w requires that been signed the should be detailed.	by	Part II. Other significant condi	itions contributing to death	but not resulting in t	he underlying cause given in P	0	tobacco use contribute to	
Š	requi	eted	Corons a	my aise	ese, CV	ronic rem	1	Yes 2 No 3 Pro	bably 4 Honknown
20	e law has b	mpi	Insuttici	ency,	Seizur	es -	24a. Wa	s an 24b. Were aut prior to co	opsy findings available ompletion of cause of
<u></u>	n; Th ficate r, pag		05.111	U	···-		1 Yes	formed? death? 1 Yes	21 No
Division of Vital Becords D.O. Box 6.	sicial certi	o Be	25. Was case referred to medie examiner? 1 Yes 2 No	Hospital:	0 T F D (0)	Oth	lace of Death (Check only		
ţ	erthis	n: To	27. Manner of Death	28a. Date of Inj	ury 28b. Tin	atient 3 DOA 4L		sidence 6 Other (Speci	59)
	Attanding death. ctor: Aft y the fun	atio	1 Natoral 5 Pend 2 Accident inves	ding (Month, Distingation 9)24	104 05	Work? M 1 ☐ Yes 2	20No Fa	11	
<u>Şi</u>	al or Attand efter death Director; /	Certification:	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	d not be mined 28e. Place of In building, e	jury · At home, farm	, street, factory, office	28f. Location	(Street and Number or Rur	al Route Number,
	ital o ris eff ral Di				<i>V</i>	10 me	2121	Coon Club	Rd Wedning
	The Hospital or Attanding Physician: The law requires that the death certificate be executed in 24 hours elect death. The Funant electro: After this certificate has been signed by the attending physicien and netled in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transities.	Medical	29a. Certifier 1 Certify (Check only 2 Medic	ar Cadiminer. Off the Dasis	JI BAGITIII I GUOTI ALIUVI	death occurred at the time, date or investigation, in my opinion,	e and place, and due to the death occurred at the time	e cause(s) and manner as s , date and place, and due t	stated. MN 21157 to the cause(s)
	To the Hoapital or Attanding Physician: The within 24 hours elter death. To the Funaral Director: Atter this certificate he completely filled in by the funeral director, page	Med	29b. Signature and title of certif	and mainers	tated.	29c. License numb		29d. Date signed (Month,	
	A .		Danlan d	or Nd.	Mn	O., T	1565	Oct 1	1))0006
	MARIN		30. Name and address of person	priwho completed cause of	death (Item 23a) (To	/pe. Print) 2401 W. As	LYEDERE AVE.	BALTIMASE M	D 121215
	3		Wesley	HSu. W	n /	nai Hasp	ital of	Baltima	- 2/1/3
	Sta		31. Date filed (Month, Day, Yea		rar's Signature				
	Registi 	ar	OCT	1 9 2004	seve &	Spark			and the state of t

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death Decedent's Name (First, Middle, Last) **Physician** 15 2004 6:40 p M October Eva Charlotte Kirk /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll 640 Uniontown Road Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 21 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex ^{Year} 1922 **Funeral** Days Min. Months Hours 1 □ M 2 XX 82 214-18-7409 Director Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State or 28a-f show the Medical Examiner must be nutilied at 1 ☐ Yes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21158 USA Items 23a 640 Uniontown Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ MM Specify: Specify: δ White 3 Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7. Department of Health and Menial Hyglene. Important: If item 27 is marked other than "ns any injury or other traumatic event, Tre Medis 2006. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Elsie Bond George Henry Fuhrer, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 640 Uniontown Road Westminster, MD 21158 Patricia Kirk/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 10/2004 1 Burial 2 Cremation 3 Removal from State Evergreen Memorial Gardens Finksburg, MD 1 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Britts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCREATIC ANCER Pnysician 2months /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ page 2 should be 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has autopsy 2 No 1 Yes To the Hospital or Attending Physician: tor: After this certific the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural Injury 5 Pending within 24 hours after death.

To the Funeral Director: Ai
completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and atte of certifier 29d. Date signed (Month, Day, Year) 29c. License number 18/2004 731660 Jalus III remas V. MA 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Pnnt) MACY/AC 21157 WESTMIN STER THOMAS GALVIN III_M 291 STONEL AVENUE 31. Date filed (Month, Day, Year) 32. Regionar's Signature State OCT 1 9 2004 Elseva & Sperke Registrar

State of Maryland / Department of Health and Mental Hygien 0 0 L 34812 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Carl Campbell Longmire 11: 10 PM October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 1 M 2□F Yrs 70 Director 227-36-8075 14,1933 VA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Items 23a or 28a-f shor 1 ☐ Yes 2 ☐ No MD QUeen Anne's Crumpton Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 28 Matthew Drive 21628 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status r than "natural", or Items the Medical Examiner of 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 -0-Power lineman Power othar i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fil. int of Health and Mental Hy t: If itam 27 Is markad oth Ella MaeLink Ira Weaver Longmire 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Matthews Dr., Crumpton, MD 21628 Betsy Ann Longmire/Wife othar 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State injury or permit. Page Department o Important: If any injury or once. Crumpton Cemetery Oct. 19,2004 Crumpton, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Fellows, HElfenbein & Newnam, P.A. 21. Signature of Funeral Service License 130 Speer Rd., Chestertown, MD 21620 23a. Part1. Enter the discase, or amplications as heart failure. List only onns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only cause on each line Immediate Cause (Final Preumonia **Physician** MKNOWN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) P.O. the signed by to Id be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an rmed? 2**X** No this certificate 1 Yes director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the within 24 hours after deat To the Funaral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier every Kampp MD P18538 October 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MJ 225. Greene St. Kampp 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 1 8 2004 Registrar

			* Hegistrar	Maryland / Depa	artment of F	lealth and Death	,	reg. No.	
	Physici	an	Decedent's Name (First, Middle, Last) FRANK WILLIAM LYNC	н			2. Date of Dea Month	Day Yea	R.A
	/Medic Examin		4a. Facility Name (If not institution, give street and number		4b. City, Town, o	r Location of Deal	10 th	15 2004 4c. County of D	
	LXdiiiii		Snow Hill Nursing and I	Rehabilitation	Center	Snow H	Hill	Worces	ster
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 ☐ F	. Age (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	Hours Min		y, Year)	Birthplace (State or Foreign Country) PA
	ow ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	a-feh	tor	MD Wicomico	Delmai	r				1 □Yes 2X No
	or 28	Directo	10e. Street and Number		10f. Zip Code			10g. Citizen of What	Country?
	sath w		8816 Shell RD	ent Ever in U.S. 13.1	218		Specify Ves or No-	USA	merican Indian,
36	be filed within 72 hours after death with the Maryland ital Hygiene. did other then "neturel", or items 23a or 28a-f ehow event, the Medical Evarifier must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deced Armed Force Armed Force 4 Yes, Give	[™] wwii	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes ※☐ No	Specify:	to Rican, etc.)	Black, W Specify:	hite, etc. White
Š	72 hou	ted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occup		ndkina	16b. Kind of Busine	ss/Industry
2	ithin 7	Completed	Elementary/Secondary (0-12) College (1-	for 5+)	DO NOT use retired	d) -	, and	.	
	filed w Hygier ther th		12 17. Father's Name (First, Middle, Last)	Maste	er Electr		me (First, Middle,	Electric Maiden Sumame)	al Co.
Maryland 21215-0036	be de la la la la la la la la la la la la la	To Be	James B. Lynch			Emma	Shane		
Nar	2 sh and is m		19a. Informant's Name/Relationship (Type, Print)		_			r, City or Town, Stat	
	1 and Health Iem 27 other tr		Shane Spain 20a. Method of Disposition	20b. Place of Dispo	Harmon sition (Name of		Date Date	20c. Location - City	21863 or Town, State
DE L	00 0		1 ■ Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)				0/19/04	Girdletree	- MD
Baltimore,	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licensee					Funeral H	
Ö	Per la la la la la la la la la la la la la		1 tacqueline 1 1	MADRILL 4	108 W. F	ederal S	t. Snow	HIII, MD	21863
E			23a. Part1. Enter the cisease, or complications that ca shock, or heart failure. List only one suse on ea	the leath. In no ent	er the mode of dyir	ng, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
X	Physician		Immediate Cause (Final disease or condition resulting in death)	ing (ucer				Oriset and Death
	/Medical Examiner		Due to (o	r as a consequence of):					
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	r as a consequence of):					
	cuted nd ransit	Examin	trat initiated events c						
Ö,	e execian ar		resulting in death) Last Due to (o	r as a consequence of):					
8760,	icate be executed physician and s the burial-transit	dicai	d						
9 ×	eath certific attending p I for use as	/Me	IF FEMALE: 23c. If yes, outc	ome of pregnancy				23d. Date of	delivery
Вох	death e atter d for L	Physician/M	in the past 12 months? 4 Pregna	nt at time of death 5]Ectopic pregnancy] Other (s <i>pecify)</i> _	<u>′ </u>		Month	Day Year
P.O.	at the by the tache	hys	9 ☐ Unknown 9☐ Unknow	vn					
	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	by	Part II. Dther significant conditions contributing to dea	ath but not resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death? Probably 4 □Unknown
000	w require been si should I	Completed							
Rec	ne law has l ge 2 s	ldm					24a. Was autop	sy prior rmed? death	
g			25. Was case referred to medical			36 Place of De	1 ☐ Yes ath (Check only of		es 2□No
\geq	ysicien: is certific director,	To Be	examiner?	patient 2 ER/Outpatier	nt 3 DOA Oth	O.C.		lence 6 Other (S	pecify)
0	ding Phone		27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month)	Injury 28b. Time or , Day Year) Injury	28c. Injur Wor			low injury occurred	
Siol	tendir leath. tor: A! the fu	catic	2 Accident Investigation		M 1 🗆	Yes 2 □ No			
Division of Vital Records,	or Att	Certification;	determined 286. Place	of Injury - At home, farm, str g, etc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Tow		Rural Route Number,
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, is	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the I	sis of examination and/or in					
	ro the vithin or the omple	Med	29b. Signature and title of ceptifier		29c. Licens	e number	1	29d. Date signed (Mo	
	·- > F 0		South		05	4422		10-15	- 2004
+	1, 11+1		30. Name and address of person who completed cause U30 - W. M. W. S.	St. : (,	H was	TII . ,	M)	21863	Sarad Baral, MD
· ·	Sta Regist	ate rar	31. Date filed (Month, Day, Year) OCT 2 0 2004 32.	gistrar's Signature	mile				

		1 - For State Registrar	State	of Marylar		artmen rtificate			and M		giene 0	04	34814
Physici /Medic	al	Decedent's Name (First, Midd Evelyn W. Lied As. Facility Name (If not institution)		um <i>ber</i>)		4h City	Town or	Location o		2. Date of Dea Month Oct. 14	Day 2004	Year ty of Death	3. Time of Death
Examin Funeral	er	Chester River 5. Social Security Number	Hospital	,	last birthday)	Chest	terto	OWN If Under:	24 Hrs.	8. Date of Birt	Kent		lace (State or Foreign
Director		211-20-4278 Usual Residence of Decedent	1 □ M 2 AF		30 Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Day Feb. 9,	1924	PA	try)
death with the Maryland rms 23a or 28a-f ehow	Funeral Director	PA Chest 10e. Street and Number 1084 Wayne Ave	er		ty.Town or Lo	.1e	Code				10g. Citizen of		Od. Inside City Limits Yes 2 No try?
after or Ita	by	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorced	12. Was De Armed F ried 1 \(\subseteq Yes	2 No			lent of Hi	spanic Oric n, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)		ce-Americ ack, White, e	etc.
A LA Aleman or then t, libs M	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle,	-0-	(1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us eeper	k done d e retired,	uring most			16b. Kind of E		lustry
E da la p	To Be	Tobias Wanner 19a. Informant's Name/Relations			19h Maili	a Address		Horte	nsia	(First, Middle, Martir Route Numbe	1		Codel
C, N 1 and 1 and 1 ealth 1 ealth 1 ther t		Richard Elenswo 20a. Method of Disposition 1 Spurial 2 Cremation	orth//Nepl	20b F	104	Swine	hart	Road	l, Co	atesvil	lle, PA	19320)
Daltimor permit. Pages Department of I Important: If Itu any Injury or o		4 ☐Donation 5 ☐ Other (S 21. Signature of Funeral Service		10	22 F	Name and	d Address	s of Facility e1fen	bein	& Newn	nam, P.	Α.	,
Certificate be executed Certificate be executed Example: Italian and private as the burial-transit	dical Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	aDue to	(or as a consequence of the cons	uence of):	1		CW			est,		Approximate Interval Between Onset and Death
death certific	Physician/Med	IF FEMALE: 23b. Was decident pregnant in the past 2 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pregna birth 2 Feta mant at time of d nown	Ideath 3	Ectopic pre Other (spe						ite of deliver	y Day Year
The law requires that the law requires that the law seen signed by the lagge 2 should be detached.	by	Part II. Dther significant condition	ons contributing to c	death but not res	ulting in the u	nderlying ca	iuse give	n in Part I.		23e. Did tol	1		e cause of death?
The larate has	e Completed	25. Was case referred to medica				-					ned? 2 🗓 No	prior to com death?	sy findings available pletion of cause of
ys dir	To B	examiner? 1 Yes 2 No 2 Manner of Death 1 Natural 5 Pendir 2 Accident investir	Hospital: 1 28a. Date (Mor	Inpatient 2 of Injury oth, Day Year)	ER/Outpatien 28b. Time of Injury		Other	4 🗆 Nur	sing Hom	(Check only on the 5 ☐ Reside 8d. Describe ho	ence 6 Oth		
To the Hospital or Attanding Ph within 24 hours attended ho To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 6 Could 4 Homicide determ	ined 286. Plac build	e of Injury - At ho ling, etc. (Specif	y) 					8f. Location (St City or Town	n, State)		
the Hosp thin 24 hou the Fune mpletely fil	Medical	29a. Certifier (Check only one) 2 Medical 29b. Signature and title of certifie		e best of my kno pasis of examina nner stated.	wledge, death tion and/or inv	estigation, i	it the time in my opi	nion, death	place, ar occurre	d at the time, d	ate and place,	and due to t	he cause(s)
7 2 3	_	• 0-	m	_ MC		2) ()(051	78	6	9d. Date signe	- N	/
Sta Registr		30. Name and address of person 400 SPCC1 31. Date filed (Month, Day, Year)	- ROI	Ches Registrar's Signa	tert	OW	1	mo	1 2	1620	O 4. F.	ergus	sow, MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie For Stata Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ANNA LINTHICUM OCTOBER 13 2004 2.30p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Director 90 1914 Maryland 578-20-0394 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar mast by modified at 1 Yes No Director Clarksburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20871 U.S.A. 26400 Clarksburg Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Public School n and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Worker System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Watkins Nora Charles H. Barber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26400 Clarksburg Road, Clarksburg, Maryland 20872 Mary Ann Beall - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If its any injury or ott 2 Cremation 3 Removal from State 1 Degrical Oct. 18, 2004 Germantown, Maryland Salem Cemetery 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Olin L. Molesworth P.A., Funeral Home overt Road, Damascus, Maryland such as cardiac or respiratory arrest, 20872 26401 Ridge Road, 23a. Part1. Ente #15 disease, or complications that cause the death, shock, or heart failure. List only one cause on each lie. Approximate Interval Betw Onset and Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events signed by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 🔲 No 2/2/No 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature 29c. License number 29d, Date signed (Month, Day, Year) nd title of certifier completed cause of death (Item 23a) (Type, Print) MD

Registrar

State

Date filed (Month, Day, Year)

1 9 2004

32. Registrar's Signature

			1 - State Registrer	ate of Marylan		artment of F			giene 004	34816
	L. I.		Decedent's Name (First, Middle, Last)					2. Date of De	ath	3. Time of Death
	Physici /Medic		Alta M. Lowe					Octobe	er 17, 20	048:10P M
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, o	r Location of Dea	th	4c. County of Dea	
			Union Hospita	1		Elktor		- 1	Ceci1	
	Funerat Director		5. Social Security Number 6. Sex 1 ☐ M	7. Age (In yrs. I	Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Da	y, Year) C	rthplace (State or Foreign ountry)
			Usual Residence of Decedent	87				Dec. 2	3,1916 V	irginia
	ryland how		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Be-f.	ctol	MD Cecil	N	orth	East				1 ☐ Yes 2√2 No
	or 24	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	s 23a	iral	77 Doctor Carr R			21901			U.S.A.	
	item item	Funeral	Α	Vas Decedent Ever in U. Armed Forces?	S. 13. V	Vas Decedent of H f Yes, specify Cuba	fispanic Origin? (an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi	
99	ai', or	by	3 Widowed 4 Divorced	☐Yes 2☐No Yes, Give X Year or Dates:	1	Yes 2No	Specify:		Specify: W	nite
21215-0036	be filed within 72 hours eiter deeth with the Maryland ital Hyglene. d other than "netural", or items 23a or 28e-f show event, the Madical Exart as must be mailled at	Completed	15. Decedent's Educatio (Specify only highest grade cor.	n (a to d)	16a. Deced	lent's Usual Occup	ation		16b. Kind of Business	
2	ithin ie.	nple		College (1-4or 5+)	life. L	kind of work done OO NOT use retired	during most of wi	orking		
7	e filed within Il Hygiene. other than '	Cor	9	_	Labo	rer/Fac			Plastic	oid
Maryland	be find H	Be	17. Father's Name (First, Middle, Last)					me (First, Middle,		
Ž	2 should be and Mental is marked eumatic ev	To	Albert Ball 19a. Informant's Name/Relationship (Type, F	Point)	10h Mailin	a Address (Chrost		ie Hort	on r, City or Town, State,	
Ma	s 1 and 2 should f Health and Men itam 27 is marke other treumatic		Nancy White/daugh	•					h East, N	
<u>6</u>	ss 1 ar		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of		Date	20c. Location - City or	
E O	m O		1 Burial 2 □ Cremation 3 □ Removed 4 □ Donation 5 □ Other (Specify)	Valifoli State	_{этвеегу, сген} 1ріп	Manor	Oct	ober 21		
Baltimore,	permit. Page Department of importent: if any injury or once.		21. Signature of June 11 Service Licensee	, 01	22	Name and Address	,	•		I I IID
8	8 Q T E 9		XXII					Funera1		
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one ca	ns that caused the death	. Do not ente	er the mode of dyin	ig, such as cardia	c or respiratory an	kton, MD	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CIVER	Vall	une				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	7 1				1/2015
	_xamino	_	Sequentially list conditions, b	MYEMI	(Lence of):	IVVIK	1511			YEG IS
Q	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	MY MIC	ience oi):	onation	40 1	7		VPOINE
.'	al-trai	xar	that initiated events resulting in death) Last	Due to (or as a consequ	ience of):	poicie	2			1000
8760,	requires that the death certificate be executed teen signed by the attending physician and hould be detached for use as the burial-transit	dlcal	L _d							
9	tificat ng phy as th	led								
Вох	eath certific attending p	Physician/Me	200. 1123 decedent programt	yes, outcome of pregnar □Live birth 2 □Fetal		Ectopic pregnancy			23d. Date of de	livery
	ne dea the at hed fo	sici	1 ☐ Yes 2 ☑ No	Pregnant at time of de		Other (specify)			Month	Day Year
P.0	that the de led by the detached		9 ☐ Unknown Part II. Other significant conglitions contribu	ting to dooth but not focus	dain on in AM a	da bita - aa		00- Bid.		
ds,	signe d be o	d by	ARINIU Maanes	sed Her	00001	oerlying cause give	en in Parti.	239. Did to	bacco use contribute to es 2 ☐ № 3 ☐ Pr	o the cause of death?
Vital Records,	w requir been si should	Completed	11 non fearing	100/	man	that				
Rec	e la has	ďΨ	HAR TONDIN	- 10000	1040	2		24a. Was a autops perfor	sy prior to	utopsy findings available completion of cause of
ta			25. Was case referred to medical					1 ☐ Yes	2 □ 1 □ Yes	2 🗆 No
		To Be	examiner? 1 Yes 2 No Hospit	tal: 1 Inpatient 2 2	======================================	3 DOA Othe		ath (Check only or	ne) ence 6 □Other (Spe	~ .
J of	g Physier this		27. Manger of Death 28		28b. Time of	28c. Injury Work			ow injury occurred	city)
ior	ending I sath. or: After he funer	atlo	Natural 5 Pending investigation	(Month, Day rear)	Injury		Yes 2 □ No			
Division	or Attending ifter death. Director: After in by the funer	Certification;	3 Suicide 6 Could not be determined 28	le. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Si City or Town	treet and Number or Run, State)	ural Route Number,
	urs of urs of arel D									
	To the Hospital or Attending Ph within 24 hours efter death. To tha Funeral Director: After th completely filled in by the funeral	edical	(Onocional Exeminer: (n: To the best of my know On the basis of examinati	vledge, death ion and/or inv	occurred at the tirr estigation, in my or	ne, date and place pinion, death occ	e, and due to the curred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
	To the within 2 To tha complet	Mec	29b. Signature and Migraf Agentityer	and manner stated.		29c. License			9d. Date,signed (Mgnt)	
)	r s F ö		() // [/////////////////////////////////	MIND		DU	5755		10/18/	2004
	10	}	30. Name and address of person who comple	ted cause of death (Item	23a) (Type. F	Print)	,,,,,		10/0	
	9		106 Bow 57	1. , EIK		mo				
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signat		<i>L</i> .				
	Registr	ar 💮	OCT 1 9 2004	HO. J IK	4					

			For State Registrar		State o	f Marylar	nd / Depa <i>Cei</i>	artment of H ctificate of I	lealth a D <i>eath</i>	and Mer	ntal Hygi	2004	34817
	Physicia		1. Decedent's Name (F	First, Middle, Las	t)						Date of Death Month	Day Year	3. Time of Death
	/Medic		Dorothy								CTOBER	16, 2004	8:35a ^M
	Examin	er	4a. Facility Name (If no 20 PARK VI	-		mber)		4b. City, Town, or WESTMIN		f Death		4c. County of Dea	
			5. Social Security Num			7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth	CARROLI	rthplace (State or Foreign
	Funeral Director		143-22-578	1	_ M 2(∑ r	76		Months Days	Hours	Min.	Date of Birth (Month, Day,		Ountry) N.J
			Usual Residence of De								LOY UH	1740	
	irylan show	_	MD 10a. State	Ob. County	-11	10c. Ci	ty, Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 (XNo
	Ba-1 s	Director		Carr	OTT		westu	unster					
	with th	Ö	10e. Street and Number					10f. Zip Code			10	g. Citizen of What C	Country?
	sath v	era	20 Park	view le		edent Ever in U	IS 13 1		1157 Ispanic Oric	nin? (Specify	Yes or No-	14. Race - Am	erican Indian
36	172 hours after death with the Maryland "natural", or items 23s or 28s-1 show clical Ezara actinust by notified at	by Funeral	1 Never Married 3 Never Married	_	Armed For 1 Yes If Yes, Give Year or D	orces? 2 ∑ No ve		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐∰o	Specify:	, Puerto Ric	an, etc.)	Black, Wh	ite, etc.
9	2 hou		15	5. Decedent's Ed	ucation		16a. Dece	dent's Usual Occup	ation		1	6b. Kind of Busines	s/Industry
21215-0036	within 7; ene. than "n	Completed	(Specify Elementary/Seconda	only highest gra ary (0-12)	College (1	1-4or 5+)	life.	kind of work done o	during most ()	or working		O- 77	
2	e filed withi at Hygiene. I other than vant, the M	Con			4			omemaker				Own Home	e
nd	D T D G	Be	17. Father's Name (Fir									aiden Sumame)	
S	should be nd Mental marked o	7	Earl Deni		Supp. Print)		10h Mailie	a Address (Street			Lepley	City or Town, State,	Zin Codo)
Maryland	2 20 20 2		Peter Lan		ype, rang			Gentry (MD 21157	Zip code)
	s 1 and 2 if Health item 27 I		20a. Method of Dispos			20b.	Place of Dispo	sition (Name of natory or other place	1	Date		0c. Location - City o	r Town, State
ê E	0 0		1 ☐ Burial 2 ☐ 4 `4 ☐ Donation 5			State		roll Cren		7 10/1	8/2004	Winfield	d. MD
Baltimore,	permit. Page Department o Important: If any injury or once.		V	ral Service Co	500	7	- Pr	Name and Address itts Func	ss of Facility	Y Home a	nd Chap	œl, P.A.	21157
			23a. Part1. Enter the	disease, or comp	olications that o	caused the dea	th. Do not ent	2 Washine er the mode of dyin	gton - F	Road cardiac or re	Westmin espiratory arre	nster, MD	Approximate Interval Between
	Pnysician		Immediate Cause (Fir disease or condition resulting in death)	ailure. List only nal	aton e	Jester	SWEA	Mercusc	(enti	i Cor	dicovoy	ola Dis	Onset and Death
	/Medical Examiner				Due to	ras a consec	quence of):						
	pe is	Examiner	Sequentially list condi if any, leading to imme cause. Enter Underly Cause (Disease or inju-	ediate ing		(or as a consec	quence of):						
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Las		c. Due to	(or as a consec	quence of):					25/10/	
8760,	sician buria			l	S41								
687		edical			. u							-	
.O. Box	that the death certificated by the attending posterior of detached for use as	Physician/M	IF FEMALE: 23b. Was decedent point the past 12 mm 1 Yes 2 N 9 Unknown	onths?	1☐Live t	tcome of pregn pirth 2 Fet nant at time of d lown	aldeath 3	Ectopic pregnancy Other (specify)				23d. Date of de Month	elivery Day Year
s, P	es be	by	Part II. Other significa	ent conditions of	ontributing to d	eath but not re	sulting in the u	nderlying cause give	en in Part I.		23e. Did toba	V	to the cause of death? Probably 4 □Unknown
Record	law requir as been si 2 should	Completed									24a. Was an	24b. Were a	autopsy findings available
Re	The lav te has	mo									autopsy perform Yes 2	ed? death?	completion of cause of
Vital		0	25. Was case referred	d to medical					26. Place	of Death (C	heck only one		
of V		To B	examiner? 1XXes 2 □ No	0	Hospital: 1	Inpatient 2	ER/Outpatier		4 Nu	rsing Home	5XXResider	nce 6 Other (Sp.	ecify)
n o	ding Ph h. After th funeral		27. Manner of Death	5 Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time o Injury	Worl			. Describe how	w injury occurred	
Sio		icat	2 Accident 3 Suicide	investigation 6 Could not be		of laiune - At t	omo form et	M 1 [Yes 2 □1		Location (Str.	eet and Number or F	Rural Route Number,
Division	Dir Dir	Certification:	4 Homicide	determined	28e. Place build	ing, etc. (Speci	ify)	eet, factory, office		2011	City or Town.		ioral Productivation,
_	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 11 (Check only 22	Certifying Ph	niner: On the b	e best of my kn easis of examin	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and th occurred a	due to the car at the time, da	use(s) and manner a te and place, and du	as stated. ue to the cause(s)
	Fo the within Fo the comple	Me	29b. Signature and titl	le o certifier				29c. Licens	e number		29	d. Date signed (Mor	nth, Day, Year)
			YL	Kinh	eman			(OCME		0	CTOBER 17	, 2004
	MIL		30. Name and address	s of person who	A	se of death (Ite							
_	~		JUAK	en (D Yet	Registrar's Sign	111 Pe	nn Stree	t, Ba	Ltimor	e, Mar	yland 212	01
	Sta		31. Date filed (Month,	OCT 1 S	32. F	Register's Sign	ature	1					
	Regist	Idl		001 19	4004	MERCUR	15	South					

State of Maryland / Department of Health and Mental Hygiene 0014 34818 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 4:54P M CANH LE October 15 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☐ M 2 🕅 F 89 Director 586.32.8708 5, 1915 Jan. Vietnam Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits r then "netural", or Items 23a or 28e-f ehow the Madical Extribit ericust be notified at 1⊠Yes 2 No Maryland Montgomery Boyds Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 14401 Autrum Rust Road 20862 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Vietnam Government Social Worker 12th or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event 2008. Be Nhon Thi Dang Oanh T.e 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13408 Fountain Club Drive, Germantown, MD 20874 Anh Pham/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cem. 10/23/2004 Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HINES-RINALDI FUNERAL HOME 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part 1. Enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myoundir **Physician** w /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate that the transfer Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the burial-tran and resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician by Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify)) pe Division of Vital Records, P.O. 9 Unknown 9 Unknown be detach ģ Signed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 1 No certificate 1 Ves 2 No 1 Tyes To the Hospital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 Yes 2 No 28a. Date of Injury (Month, Day Year) the funeral 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 1 Natural 5 Pending after death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 T Homicide within 24 hours a To the Funerel 1 1 Destritying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my animinal death. 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year) IND. D0057455 October 15, 200 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil Saxena, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 18 2004 OCT oaks Registrar

			1- State of Maryland / Department Certificat	nt of Health and Mei te of Death	ntal Hygiene Reg. Nd	/ 11 11 12	34819
Ī	Physici	an	Decedent's Name (First, Middle, Last)		Date of Death Month Day		3. Time of Death
7.	/Medic Examin	-	Cyril J. Laughlin 4a. Facility Name (If not institution, give street and number) 4b. City,	, Town, or Location of Death	october 15	. 2004 County of Deatl	3:46 P M
		J.		lver Spring		Montgom	
	Funeral Director		5. Social Security Number 577.32.8252 6. Sex 1 \omega M 2 \subseteq F 7. Age (In yrs. last birthday) ff Undel Months	r 1 Year If Under 24 Hrs. 8. Days Hours Min.	Date of Birth (Month, Day, Year) an. 20, 19	9. Birth Co. New	nplace (State or Foreign untry) Crittend e York
	D		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		411, 20, 19	10 New	101 R. 10d. Inside City Limits
	Maryla f show	JO.	Maryland Montgomery Silver Spring	7			1 Yes 2 □ No
	or 28a-	irec		p Code	10g. Cit	tizen of What Co	untry?
	s 23a	ral		20904		J.S.A.	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-1 show may injury or other traumatic event, the Medical Examinate Institled at ORGE.	by Fune	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: 13. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	dent of Hispanic Origin? (Specificify Cuban, Mexican, Puerto Ric 2图 No Specify:	y Yes of No- an, etc.)	14. Race - Ame Black, White Specify: Wh	e, etc.
Baltimore, Maryland 21215-0036	72 ho "natur	eted	15. Decedent's Education (Specify only highest grade completed) (Give kind of we life. DO NOT u	ork done during most of working		ind of Business/I imals	Industry
7121	withir liene. r than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	inarian			Services
פט	al Hyg I other	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name (F		Sumame)	·
ryla	d Ment d Ment narke natic	٥	Vincent Joseph Laughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address	Ellen Ca		or Tourn State 7	Tin Code)
Ma	nd 2 si alth an 27 is r r traur			Hampshire Aver			
ore,	of Head		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Na. cemetery, crematory or cemetery, crematory or cemetery).	me of Date other place)	20c. Lo	ocation - City or	Town, State
ij	trent tant: I tant: I		'4 □Donation 5 □Other (Specify) Gate of Heave:	n Cemetery10/19	0/04 Rock	cville,	Maryland
Ba	permit Depar Impor any in		Nancy A Pagentie HINES-	^{nd Address of Facility} RINALDI FUNERAI New Hampshire A	ve,Silver	Spring	,MD 20904
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the most shock, or head-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pneumonia Due to (or as a consequence of):	de of dying, such as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death 10 Days
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
Box 68	it the death certificat by the attending phy tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 4 Pregnant at time of death 5 Other (st			23d. Date of delive	very Day Year
o	t the de	hyslo	1 Yes 2 No 9 Unknown	Jacary)			
Vital Records, P.	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in the underlying of Previous CVA	cause given in Part I.	23e. Did tobacco u	_	the cause of death?
eco	e law requ has been je 2 shoulk	Completed	Esstenial Hypertension		24a. Was an autopsy	prior to c	topsy findings available ompletion of cause of
al B			Atrial Fibrillation		performed? 1□ Yes 2₺ No	death? 1 ☐ Yes	2 No
Z.	ysician: nis certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🔀 No	26. Place of Death (COO) Other: 4 \(\subseteq \text{Nursing Home} \)		6 ∏Other (Spec	ify)
n of	ng Phy fter thi	T :uc			. Describe how injur		.,,,
Division	I or Attending Physician: after death. Director: After this certific I in by the funeral director,	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	1 ☐ Yes 2 ☐ No y, office 28f.	Location (Street an City or Town, State		ral Route Number,
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred and manner stated.				
)	To the h within 2. To the l	W	10	c. License number D - 03835	Octo	te signed (Month ber 15,	
	lo		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) David K. Cromwell, M.D., 831 University Bo	Suite # oulevard East.		ring.MD	20903
	, Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Regist	ar	OCT 18 2004 Some & Spa	uks'			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] [] 34820 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Voar **Physician** Felix Alicea Lopez actober 2246 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Memorial Hospital at Easton Taibot Eastan If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 100 M 2□ F 583-70-5871 45 Director 1959 Puerto Rico Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event. The Medical Examinal must be notified at 1 XYes 2 ☐ No Directo Caroline Maryland Ridgely 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 206 Maple Avenue 21660 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Maritat Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 □ No þ Specify 3 Widowed 4 Divorced Puerto Rican Puerto Rican Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If item 27 Is marked other than ' Elementary/Secondary (0-12) Coltege (1-4or 5+) 12 Roofer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Felipe Lopez <u>Paula Alicea</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or othar trau Michelle Paige Morris/Friend P.O. Box 234, Ridgely, MD 21660 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) MidShoreCremationCenter10/14/2004 Cambridge, Maryland 21. Si ryak re of Funeral S rvice icensee Mid Shore Cremation Center, P.O. Box 1464, 2272 Hudson Rd., Cambridge, MD 21613

Approximation List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** month /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence on Examine and I-transit The law requires that the death certificate be executed physicien ar Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medical attending ph d for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 2 🗆 No 3 Probably 4 Unknown Yes Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan has 2 X No Division of Vital 1 Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death Check on one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. DeShields 509 Idlewild Avenue, Easton, MD 21601 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

and Mental Hygiene

	For	State of Maryland / Department of Health a
•	Stete Registrar	Certificate of Death
_		

October 18, 2004

Physician
/Medical
Examiner

Funeral

Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturet", or items 23a or 28e-f show importent: if item 27 is marked other than "neturet", or items 23a or 28e-f show injury or other treumatic event, the Medical Examinat must be notified at ence.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transi ned by the a within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

	1 - Stete Registrar		Cer	tificate of L	Death	F	Reg. No. U	J 4	34821		
	1. Decedent's Name (First, Middle, La	st)				2. Date of Dea	ath		3. Time of Death		
1	Stephen Micha	el Menosky	У			October	18, 20)04	12:21 A™		
il r		Stephen Michael Menosky Stephen Michael Menosky Stephen Michael Menosky Facility Name (If not institution, give street and number) Route 450 near Huntwood Drive Rocial Security Number 6. Sex 7. Age (In y 17 - 92 - 1261 1		4b. City, Town, or	Location of	Death	4c. Count	y of Death	1		
	Route 450 pear Hu	intwood Dri	ve	Gambri1	.1s		Appe	Δημο	del County		
	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	If Under 24	Hrs. 8. Date of Birt	h	9. Birtho	lace (State or Foreign		
	217-92-1261	M 2□F	25 Yrs.	Months Days	Hours	Min. March &	3, 1979	Mary	Tand		
	Usual Residence of Decedent										
	10a. State 10b. County		10c. City, Town or Lo					1	0d. Inside City Limits		
25	Maryland Anne Aru	ndel	Croft	on					1 □ Yes 2 X No		
E e	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?		
	1530 Ellsworth A	venue		21114	+		USA				
ē	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. V								
2	1 X Never Married 2 ☐ Married	1 ☐ Yes 2 Ñ No	0	I□Yes 2 No	Specify:	action mean, cici,	Speci	ck, White, גיי זעל	ite		
5	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		10 763 20110	ороспу.		Эресі.	y. W11	100		
Completed by Funeral Director			16a. Deced	lent's Usual Occupa kind of work done o DO NOT use retired,	ation furing most o	of working	16b. Kind of E	lusiness/In	dustry		
ğ	Elementary/Secondary (0-12))								
5			New C	ar Salesp			Automo				
e D				į		Name (First, Middle,		,			
0						or Ann Foll					
				•		or Rural Route Numbe			,		
		sky (father				ue Crofton			21114		
	20a. Method of Disposition	Bamoval from State	20b. Place of Dispo- cemetery, cren	sition (Name of natory or other place	θ)	Date	20c. Location	-			
			Metropoli	tan Crema	itory :	10/21/2004	Alexan	dria,	VA		
	21. Signature of Fuperal Service Licer	1500	11 22	. Name and Addres	s of Facility	Beall Fund	eral Ho	me			
	1611	10 Jean	6	512 NW Cr	ain lh	yy. Bowie,	Maryla	nd 20	715		
	23a. Part1. Enter the disease, or com	plications that caused t	he death. Do not ente	er the mode of dying	g, such as ca	rdiac or respiratory ar	rest,		Approximate Interval Between		
	Immediate Cause (Final	one dated on basic mile	Marithala	Parinic					Onset and Death		
	resulting in death)	a Due to (or as a	consequence of):	Lyunes							
ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):								
edical Examiner	Cause (Disease or injury							1			
X	resulting in death) Last	Due to (or as a	consequence of):								
S		d									
ğ		_ 0.					-				
Ξ	IF FEMALE:						23d. Da	ite of delive	nry		
by Physician	in the past 12 months?	4□Pregnant at ti		Ectopic pregnancy Other (s <i>pecify)</i>			Me	onth	Day Year		
2		9□ Unknown									
2	Part II. Other significant conditions of	contributing to death but	t not resulting in the ur	nderlying cause give	en in Part I.	23e. Did to	bacco use con	tribute to th	e cause of death?		
g D						1 🗆 Y	es 21/2/No	3 🔲 Prob	abiy 4 □Unknown		
9						24a. Was a	246	Wore auto	psy findings available		
Completed						autop	sy		npletion of cause of		
	1					1 ☐ Yes	2 X No		2 No		
0	25. Was case referred to medical examiner?	Hospital:		Othe	200	Death (Check only or			7		
0	1X Yes 2 No	1 inpatien		1 3 DOM	4 🔲 Nurs	ing Home 5 Resid					
0	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c, Injury Work	at ?		ow injury occur	in pusse	inger in vehicle		
car	2 Accident investigation 3 Suicide 6 Could not b	1011810-			res 2 XNo			- , ,			
E	4 Homicide determined		ry - At home, farm, stre (Specify)	eet, factory, office		28f. Location (S City or Tow	treet and Numi n, State)	per or Rura	AME Avendes		
á		Sta	ect			Pt. 450 Neu	a Huntu	and 4.	(intue)		
J											
dedical Certification:	29a. Certifier 1 Certifying Ph	nysicien: To the best of miner: On the basis of e	my knowledge, death	occurred at the tim	e, date and pointion, death	olace, and due to the o	ause(s) and m	anner as st	ated.		

State

Registrar

Painela E. 31. Date filed (Month, Day, Year)

OCT 2 0 2004

Southeyl, MD

30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Dr. mair. F Louithaul MA 111 Penn Street, Baltimore, Maryland 21201

OCME

			1 - For State Registrar	State of	Maryland	l / Depa	artment of rtificate o	Health f Death	and M		giene Reg. No. 20	04	34822
	Physici /Medi		1. Decedent's Name <i>(First, Middle, L</i> ALFRED	ast)	MORGAN					2. Date of Dea Month October		Year 04	3. Time of Death 11:50pm ^M
1	Examir		4a. Facility Name (If not institution, g	ive street and num	ber)		4b. City, Town	, or Location	of Death		4c. County		-1, -
			St. Thomas More	_			Hyatts				Princ	e Ge	orges
	Funeral Director		5. Social Security Number 6. 578-36-2519	Sex 7 12 M 2 ☐ F	7. Age (In yrs. la:	st birthday) Yrs.	If Under 1 Yea Months Day			8. Date of Birth (Month, Day August	1,1931	9. Birth	place (State or Foreign ntry) nington D.C
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside City Limits
	e Mary 3a-f sh	ctor	D.C.		Wash	ningto	n						1 X Yes 2 □ No
	ith th	E E	10e. Street and Number				10f. Zip Code				10g. Citizen of	What Cou	ntry?
	s 23e	ra	5393 Chillum Pla				2001				U.S	•	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examinar must be invilled at once.	by Funeral Director	Never Married 2 Married Widowed 4 □ Divorced	Armed Ford	2 □ No		Was Decedent of f Yes, specify Cu I □ Yes 2阪 N			cify Yes or No- Rican, etc.)	14. Rad Blad Specifi	ck, White,	_
8	hour	ed b	15. Decedent's		.es:	16a. Deced	lent's Usual Occ	unation			16b. Kind of B	Blac	
Baltimore, Maryland 21215-0036	nin 72 Ba'' ni	Completed	(Specify only highest g		1or 5+)	(Give life. I	kind of work don DO NOT use reti	e during mos red)	st of workin	ng	TOD. KING OF D	u3111033/111	dustry
212	d with giene er the	E O	12th	College (1-	401 3+)	Nurse					Federa	1 Gov	vernment
덛	al Hy d other	Be	17. Father's Name (First, Middle, Las	st)				18. Moth	er's Name	(First, Middle,	Maiden Suman	ne)	
yla	buld b Ment arkec	2	Alfred L. Morgan							cille 1			
ā	2 sho		19a. Informant's Name/Relationship				g Address (Stree						,
e,	1 and Healtl em 27 ther 1		Karen Morgan/Dau 20a. Method of Disposition	gnter	20b. Pla	ce of Dispo	0 Cherr		_		20c. Location -		
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rds, P.	w requires that the been signed by should be detact	ρ	Part II. Other significant conditions ESRD, PVD, DEMEN		th but not resulti	ing in the ur	iderlying cause g	iven in Part I			_		e cause of death?
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on of	ding I	tlon: To	27. Manner of Death 1 公Natural 5 Pending 2 Accident investigation	28a. Date of (Month,		8b. Time of Injury	28c. Inj	al Alan	28	e 5 Reside			')
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	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical (29a. Certifying F (Check only one) 1 Medicel Exe	Physician: To the base aminer: On the base and manne	is of examination	edge, death n and/or inv	occurred at the estigation, in my	time, date an opinion, dea	d place, ar	nd due to the ca	use(s) and ma ate and place, a	nner as st and due to	ated. the cause(s)
)	within 2 To the complet	Ň	29b. Signature and title of certifier Mun Sand	2/1	Zm.		100	se number	708	1	od. Date signed	2	U
f	(8)		30. Name and address of person who	completed cause		3a) (Type, 1	Print) South	ern Av	le 515	= ar 307	Washin	igton	. D. C. 20032
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0 20	04 Reg	gistrar's Signatur	for	w						

			State of Maryland /	Department of Certificate of			20 Sene	04 3	4823
	Physician /Medical	Decedent's Name (First, Middle, Last) JAMES SAMUEL MI	TCHELL			2. Date of Death Month October	Day 12, 20	Year 004 5	Time of Death
F	Examiner	4a Facility Name (If not institution, give s Holy Cross Hospic			4b. City, Town, or Lo Burtonsvi		Montge		
Ī	Funeral Director	5. Social Security Number 6. Sex 254-20-2461	M 2□ F 80	Yrs. If Under 1 Year Months Days		8. Date of Birth (Month, Day,) Nov. 19,	^(ear) 1923	9. Birthplace (Country) Atlanta	State or Foreign
	e Maryland La-f show Utled at	Usual Residence of Decedent 10a. State 10b. County Maryland Prince Ge		wn or Location .tol Heights				10	side City Limits XYes 2 ☐ No
	3a or 28	10e. Street and Number 4906 Heath Street		10f. Zip Code 20743				Vhat Country? States	
020	within 72 hours after deeth with the Maryland ane. then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at ampleted by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No NaV If Yes, Give 1943 Co Year or Dates: 1946	13. Was Decedent of If Yes, specify Cul		ecify Yes or No- Rican, etc.)		e - American find k, White, etc. Blac	
Maryland 21215-0020	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylar Depertment of Health and Mental Hygiene. Important: If Nem 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumetic event, the Medical Examiner must be notified at page. To Be Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 9th	College (1-4or 5+)	a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin Carpenter	during most of work	ing 16	Priv	siness/Industry	
/land	2 should be filed within and Mental Hygiene. Is marked other than surradic event, the March To Be Comp	17. Father's Name (First, Middle, Last)	ne11			e (First, Middle, Ma Lester	aiden Surnam	e)	
	1 and 2 should Health and Men em 27 la merke ther traumetic	19a. fnformant's Name/Relationship (Type Gloria A. Mitchel	1/Spouse	9b. Mailing Address <i>(Stree</i> 4906 Heath S		ol Height	s, MD.	20743	
Baltimore,	permit. Peges 1 Depertment of He Important: If Ner any Injury or oth	20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R □ Donation 5 □ Other (Specify)	ceme	of Disposition (Name of lery, crematory or other pla and Veterans	s Cem. 1	0/20/04 Ch	e1tenh		
Balt	permit. Deperti Import any inj ance.	21. Signature of Funeral Service Livense 23a. Part1. Enter the disease or complishock, or heart failure.	W/ hol	22. Name and Addr	5. F	ope Funer 538 Mar1b orestvill or respiratory arres	oro Pi	ke 20747	oximate
	Physician /Medical	shock, or heart failure. Let only on Immediate Cause (Final disease or condition resulting in death)	END. STAGE CHE					Inten	val Between et and Death
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P.O.	requires that tha death certificate is signed by the attending thould be detached for use as the death by Physician/Me	Part If. Other significant conditions con	tributing to death but not resulting	in the underlying cause g	iven in Part I.		acco use con	atribute to the o	ause of death?
of Vital Records,		DEMENTIA				24a. Was an performe		available	ion of cause
ital Re	certificate has rector, page 2	25. Was case referred to medical				1 ☐ Yes	2 🖳 No	1 □ Yes	2 X) No
	\$ 10 D	1 ☐ Yes 2 🖾 No		Time of 28c. Injury		ome 5 Residen 28d. Describe how			SPICE
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funerel Director: After th completaly filled in by the funerel Medical Certification: "Medical Certification: "	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	3	28f. Location (Stre City or Town,		er or Rural Rou	te Number,
	To the Hospital of within 24 hours a To the Funeral D completaly filled i	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	icfan: To the best of my knowled ler: On the basis of examination and manner stated.	and/or investigation, in my	opinion, death occur	red at the time, dat	e and place, a	and due to the c	
D	within to the tenth of the tent	I alan K	legal.	m) D522	61			14, 200	
CI	R (3/1/	30. Name and address of person who co L 1517 Hugo Circle;			ALAN RTO	CHARD SEG	AL, MD		

State Registrar

31. Date filed (Month, Day, Year) OCT 1 9 2004



DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5, perINF, FH, C838, 12/22/04, TT.

			1- State Registrar		Cer	irtment of H tificate of L	ealth and Death	Reg	n2 0 0 4			
Н	Physici	an	Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Yea	r	of Death	
į.	/Medic Examir		Elnora McLendon 4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Dea	Oct. 14	4c. County of D		0 P. ^M	
	Examir	ier	Montgomery Villag			Montgome			Montgom			
	Funeral Director		323 34 3343	ex	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ear)	Birthplace (State Country) hio	or Foreign	
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside	City Limits	
	Mary -f sh	tor	MD. Montgome	ry Mon	ntgom	ery Villa	ge			1 ∏ Ye	s 2 No	
	or 28	Director	10e. Street and Number	D 1		10f. Zip Code		10g	. Citizen of What	Country?	-	
	ath w	rai	19301 Watkins Mill			20886			USA			
36	72 hours after death with the Maryland neturel; or ltems 23e or 28e-f show lical Examinar must be notilied at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ② Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	"	Vas Decedent of Hi. Yes, specify Cubar ☐ Yes 2 XNo	spanic Origin? (in Mexican, Pue Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Al Black, W	•		
ş	"neturel",		15. Decedent's Ed	ucation 1	6a. Deced	ent's Usual Occupa	ition	16	b. Kind of Busine			
21215-0036	⊆ 2 3	Completed	(Specify only highest gra- Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life. L	kind of work done d OO NOT use retired;	uring most of wo	orking				
	filed with Hygiene. other ther	Con			ice I	rincipal			Education	n		
Maryland	o d ta	Be	17. Father's Name (First, Middle, Last) Benjamin O. Davis	Sr				me (First, Middle, Ma.	iden Surname)			
Ž	s 1 and 2 should I Health and Men item 27 is marke other treumetic	٦ ر	19a. Informant's Name/Relationship (7		19h Mailin	n Address (Street a		Dickerson ural Route Number, C	ity or Town State	Zin Codol		
<u>B</u>	nd 2 lith a 27 is		Ira Scott/ Nephew	l.				. N.W. #31		20016		
ē,			20a. Method of Disposition	20b. Place	e of Dispos	sition (Name of			c. Location - City			
Ē	교 등 분 분		1 XBurial 2 Cremation 3X Removal from State 1 A Donation 5 Other (Specify) SPALDING MORTUARY 10/19/2004 LOS ANGELES, CA.									
Baltimore,	permit. Pag Department Importent: I any njury		21. Signature of Funeral Service Licen	300			s of Facility Jo	seph Gawle	r's Sons	Inc.		
ı	ş *		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the death. Done cause on each line.						Approxima Interval Be	ate atween	
	Pnysician		Immediate Cause (Final disease or condition	· Deciloit	il	Marah	DUC			Onset and	Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequent		Λ.				0000	1/2	
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	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	Dermeill	A CE					Vec	2010	
o Î	icate be executed physician and s the burial-transit		resulting in death) Last	D e to (or as a consequence	ce of):					100	47	
68/60,	ate be hysici the bu	edicai		d								
			IF FEMALE:	00- 16					1			
gox	death certific e attending p id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death	ath 3 🗌	Ectopic pregnancy			23d. Date of d Month	,	Year	
j.	0 00 0	ysic	1 □ Yes 3x □ No 9 □ Unknown	9□ Unk <i>n</i> own	1 5	Other (specify)				,		
7.	de de	by Ph	Part II. Other significant conditions co	entributing to death but not resulting	g in the un	derlying cause give	n in Part I.	23e. Did tobac	co use contribute	to the cause of	death?	
Ë	w requires been signi should be							1 ☐ Yes	2 ¹ No 3□	Probably 4 🗆]Unknown	
Vital Records,	law asb 2 sl	ompleted						24a. Was an autopsy	24b. Were	autopsy findings	available	
ř =	The ate h page	Сош						performed	1? death?	completion of o es 2 □ No	cause or	
7113	ysicien: Th is certificate director, pag	Be (25. Was case referred to medical examiner?					ath (Check only one)				
Ö	Phys this aldii	Certification: To	27. Manner of Death 1 Natural 5 Pending		Outpatient b. Time of Injury	28c. Injury Work	at ?	dome 5 Residence 28d. Describe how i		ecify) Reha	b.Cnt	
DIVISION	Attending r death. ector: After by the fune	fical	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	28 e. Place of Injury - At home,	farm stre		es 2□No	28f. Location (Stree	t and Number or i	Bural Pouto Nun	nhor	
5	al or / after I Dire d in b	erti	4 Homicide determined	building, etc. (Specify)	,,	o., .ao.o.y, ooo		City or Town, S	tate)	ISTAT FIGURE TABLE	11001,	
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical C	29a. Certifier (Check only one) Certifying Phyone)	vsician: To the best of my knowled iner: On the basis of examination and manner stated.	dge, death and/or i <i>n</i> v	occurred at the time	e, date and place nion, death occ	e, and due to the caus arred at the time, date	e(s) and manner a and place, and di	as stated. ue to the cause(s	s)	
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier			29c. License	number	29d.	Date signed (Moi	nth, Day, Year)		
•	01		> 8 Abult	may, MI)	03	1391	α	tober	14 2	004	
	:7>		30. Name and address of person who suhair H. ABULFAR	AG, MD., 15215	a) (Type, F SHADY	rint) GROVE RD	., ROCK	VILLE, MD.	20850			
	Sta Registr		31. Date filed (Month, Day, Year) OCT 19 200	32. Registrar's Signature	4	Sparks	,					

State of Maryland / Department of Health and Mental Hygienes

				State of Mary	iana / L	Certifica	ate of	Death	ivientai riy	alenes 0	04	348	125
			1. Decedent's Name (First, Middle, Lest,)		00/11/100		Douth	2. Date of De			3. Time of I	
	Physici /Medio		Evelyn Marie	Miller					Month Octob	Day er 21	Year 2004	3:50	a.m
	Examir		4e Fecility Name (If not institution, give					4b. City, Town, or					
			Moran Manor Nu					Western		All	egany		
	Funeral Director		5. Social Security Number 216-80-1811 6. Security Number 1	7. Age (In 84	yrs. lest birt	rs. Month	der 1 Year Days	Hours Min		y, _{Year)} 5 1920	9. Birthpla Countr Maryl	ce (State or y) .and	Foreign
	land ow		10a. State 10b. County	100	c. City, Town	or Location					10	d. Inside City	y Limits
	Mary	햣	MD. Allegany	•	Wes	ternpo	rt					1 Yes	2 🗆 No
	h with the	Funeral Director	10e. Street end Number 212 Philos Ave			10f. 2	Zip Code 215	62		10g. Citizen of United			
020	permit. Pages 1 end 2 should be filed within 72 hours after deeth with tha Maryland Depertment of Heelth end Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show appring injury or other traumatic event, the Medical Examinat must be notified at once.	by Funer	11. Marital Status 1 ☐ Never Married 2∑Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	in U,S.		cedent of I pecify Cub 28 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	14. Rac Bla Specif	ce - America ck, White, et y: Whit	C.	
5-0	72 hc	eted	15. Decedent's Edu (Specify only highest gred	cation e completed)	16e.	Decedent's Us (Give kind of t	sual Occup work done	pation during most of wo d)	rking	16b. Kind of B	usiness/Indu	stry	
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pu	e filec other vent,	Se C	17. Fether's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle,	Maiden Suman	ne)		
yla	ould b Ment arked	P		utherland					rie O'Ne				
, Mar	and 2 sh elth end 27 la m er traum		19a. Informant's Name/Relationship (Ty Allen Miller/ hu					and Number or R					
Baltimore, Maryland 21215-0020	Pages 1 on the nent of He int: if item		20a. Method of Disposition 12CxBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)		cemeters	Disposition (A c, crematory of Cemet	r other pla	ce) I	10/24/ 2004	20c. Location Vesterni	-		and
Balt	permit. Depertr imports any Inju		21. Signature of Funeral Service Lieshse	nella	l			ess of Facility Bo				21562	2
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d	Physician /Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	acute	V	nyoc	mlia	e my	autic.	h		Onset and De	eath 1
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ecord	The law requiras that the daath cer ate has been signed by the attandir pega 2 should be detached for usa	Completed							24a. Was a perfor	an autopsy med?	24b. Were availa comp of de	autopsy fin able prior to detion of car ath?	use
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ב	ing P	ü	27. Menner of Death 1. Natural 5 □ Pending 2. Accident investigation	28a. Date of Injury (Month, Dey Yea	28b. Ti Inj	me of jury M	28c. Injur Wor	yet k? Yes 2 ∐ No	28d. Describe h	ow injury occur	red		
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		-	30. Neme end eddress of person who cor						·	e E d			
			Dr. Jesus Tan, Fr	ostburg Pla	aza, F	rostbu	rg, M	D. 2153	2				
	Stat Registra	~	31. Date filed (Month, Dey, Year) 0CT 2 1 20	32. Registrer's S	ignature	Sand	B						

IAI	I O MAT	ΓIN	IGLY 1 - Stete Registrar	State of M	aryland / Depa	artment of rtificate of	Health and M	lental Hyg	ien 2004	34826
	Physic /Medi		1. Decedent's Name <i>(First, Middle, L</i> as Lilian Opa		ngly			2. Date of Death		3. Time of Death 9:41 A M
	Exami		4a. Facility Name (If not institution, give CALVERT MEMORIAL	e street and number) L HOSPITAL			or Location of Death FREDERICK		4c. County of De CALVE	ath IRT CO
	Funeral Director		5. Social Security Number 6. S 217-44-3158 Usual Residence of Decedent	ex 7. Ag □ M 2区 F	ge (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, May 19,	9. Bi 1945 Was	inhplace (State or Foreign Country) Shington, DC
	ne Maryland Be-f show	ctor	10a. State 10b. County MD Calver	rt	10c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Dire	10e. Street and Number 1930 Appaloosa	Mov		10f. Zip Code	700	10	g. Citizen of What C	ountry?
960	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Itam 27 is marked othar than "natural", or Itams 23a or 28e-f show any injury or other traumatic avant. I're Medical Evar, it are matter be rudified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:			736 Hispanic Origin? (Spe pan, Mexican, Puerto I Specify: Puer		USA 14. Race - Am Black, Wh Specify: W	
21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or	(Give	dent's Usual Occu kind of work done DO NOT use retire titute Te	during most of workir nd)	ng	6b. Kind of Business Public Ed	
	uld be filled fental Hygir rked othar lic avant.	To Be Co	17. Father's Name (First, Middle, Last) Juan S. Viera		2400		18. Mother's Name		aiden Sumame)	ucation
, Maryland	and 2 shou alth and M 127 is mar er traumat		19a. Informant's Name/Relationship (7) James Mattingly			ng Address (Street Appaloose	and Number or Rura			Zip Code)
Baltimore,	Pages 1 and nent of He ant: If Itam		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		20b. Place of Disportant Courtern I	sition (Name of natory or other pla Mem. Gard	dens 200		oc. Location - City of Cunkirk, M	
Balt	permit. Departr Imports any inj		21. Signature of Funeral Service Licen		82	Name and Address South	ess of Facility Lee nern Maryl:	Funeral and Blvd		vert, PA , MD 20736
	Pnysician /Medical Examiner		23a Part1. Enter the disease or compands, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a Due to (or as	the death. Do not ent ne.		ng, such as cardiac of		A	Approximate Interval Between Onset and Death
8760,	ate be executed hysicien and he burial-transit	ical Examiner	Sequentially list conditions, it any, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of):					
.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	Ectopic pregnancy	/		23d. Date of de Month	livery Day Year
Ω.	v requires that been signed b should be deta	by	Part II. Other significant conditions co	entributing to death b	ut not resulting in the ur	nderlying cause giv	ren in Part I.	23e. Did toba		o the cause of death?
al Records,		Completed						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Vital	Physician: This certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ★ Yes 2 □ No	Hospital:	*/TED/O	act now Oth	26. Place of Death			
ion of	ding h. After fune	-1	27. Manner of Death 1 Natural 5 Pending investigation	1 ☐ Inpatie 28a. Date of Injui (Month, Day	ry 28b. Time of	28c. Injur Wor	y at 28	e 5 Residen	ce 6 Other (Sperinjury occurred	city)
=	in the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc	ury - At home, farm, stre c. (Specify)	eet, factory, office	28	Bf. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
	To tha Hospitel or At within 24 hours after or To tha Funaral Diract completely filled in by	edicai	Medicel Exem	vsicien: To the best of iner: On the basis of and manner sta	of my knowledge, death examination and/or inv ited.	occurred at the tir estigation, in my o	ne, date and place, ar pinion, death occurred	nd due to the cau d at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	with To	Σ	29b. Signatule and title of certifier	mi		29c. Licens	e number M E		Date signed (Monti CTOBER 15	

State Registrar

oss of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

		1 - For State Registrar	State of I	Marylan		rtment of I		Mental H	ygiene Reg. No.	11114	34827
Physiciar /Medica		1. Decedent's Name (First, Midd RUTH MARGARET	McCANN					2. Date of D Month Octob	Day	Year	3. Time of Death
Examine		4a. Facility Name (If not institution Peninsula III 5. Social Security Number	gional med	ical C	Enter last birthday)	4b. City, Town, o	Sby/4	eath	4c.	County of Death	n V <i>iCO</i>
Funeral Director		578-16-4108 Usual Residence of Decedent	1□M 2∰F	84	Yrs.	Months Days	Hours M	in. (Month, L	Day, Year) 1920 1920	O OHIO	nplace (State or Foreigr untry))
the Maryland	ctor	MARYLAND WICOM			y, Town or Loc LISBURY						10d. Inside City Limits 1 ☐ Yes 2 📉 No
6 XXLS Interest to Sale of the Market Barrelline Sale or 28a-1 and prince must be notified.	erai Dire	31830 MT. HERM				10f. Zip Code 21804				izen of What Cou	
5-0036 72 hours after de netural', or item	2	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☒ Divorced	If Yes Give	s? <u>X</u> No	lf lf	Vas Decedent of P Yes, specify Cub ☐ Yes 2 1 No		(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Amer Black, White Specify:	
1215-00; within 72 hours sine. Then "netural" the Medical Expension of	Completed	(Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)	or 5+)	(Give I lite. D	ent's Usual Occup kind of work done O NOT use retire	pation during most of w d)	vorking		ind of Business/li	ndustry
re, Maryland 21215-0036 re, Maryland 21215-0036 Health and Mental Hygiene. Item 27 is marked other then "netural", or items 23e or 28e-1 ehon other treumstic event, the Medical Examinat must be notified at	o de Co	12 17. Father's Name (First, Middle, HARRY RINDERLE	Last)		SECRE	TARY		lame (First, Middle T. TOMA)	le, Maiden		VERNMENT
C. Ca. M. R. Te, Maryland 1 and 2 should be file Health and Mental Hy iem 27 is marked oth other treumstic even T. D. D.	The same of the sa	19a. Informant's Name/Relations STEPHEN J. McCA					and Number or	Rural Route Num.	ber, City or		ip Code)
Page Dent o		20a. Method of Disposition 1 XBurial 2 Cremation 4 Donation 5 Other (5		te C	lace of Dispos emetery, crem	ition (Name of atory or other place MEMORIA	сө)	Date	20c. Lo	cation - City or T	Town, State MARYLAND
Baltimo Permit Page Department Importent: If eny injury on once.		21. Signature of Fineral Service	13/5/	les	ZE: P•	Name and Addre LLER FUN O BOX	ERAL HON 3171, SA	ME, 1212 ALİSBURY	OLD MD	OCEAN C1 21802	ITY ROAD
Physician /Medical	(234 Part 1 Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on each	i line.						34	Approximate Interval Between Onset and Death
Examiner	ii lei	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Large	left as a consequ	rence or):			lomp re	and		
876(ate be hysicia the bur	IIcal Exa	that initiated events resulting in death) Last	c. <u>B) t</u> Due to (or a	as a consequ		ntus	Sienz				
Box 6 eath certif	ysicial vine	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3 🗆	Ectopic pregnancy Other (specify)	у		2	23d. Date of deliv Month	very Day Year
cords, P.O. B wrequires that the death been signed by the atte should be detached for	בַּ	Part II. Other significant conditi	o ns contributing to death	but not resu	ulting in the un	derlying cause giv	en in Part I.				the cause of death?
Vital Record icien: The law requir certificate has been si rector, page 2 should										24b. Were auto prior to co death? 1 \(\subseteq Yes	opsy findings available ompletion of cause of 2 No
To T	2	25. Was case referred to medical examiner? 1 Pres 2 No 27. Menner of Death 1 Matural 5 Pendir 2 Accident investi	Hospital: 1 Impa 28a. Date of Ir (Month, I		ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing	eath Check online Home 5 Res 28d. Describe	idence 6		(y)
in Signal		3 Suicide 6 Could 4 Homicide determ	ined 286. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory, office		28f. Location City or To	(Street and own, State)	1 Number or Rura	al Route Number,
Div To the Hospital or within 24 hours afte To the Funeral Div completely filled in Medical Cert		one)	g Physician: To the be Examiner: On the basis and manner	of examinat	wledge, death ion and/or inve	estigation, in my o	pinion, death oc	ce, and due to the curred at the time	, date and _l	place, and due to	o the cause(s)
To cor		29b. Signature and little of cortifie	1	/	10	29c. Licens				signed (Month,	
		30. N/ and address of son Y W / U Y Z W 31. Date filed (Month Day Year)	o completed cause of 560 Riv	f death (Item Strar's Signal	23a) (Type, P	A102	Salis	ovry)	md	. 7180	04
State Registrar		/ OCT 1	4 2004	Source .	Mr. A						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34828 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 18, 2004 Orient Neira 10:56PMM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 12419 Canfield Lane Bowie Prince Georges 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 1X M 2 ☐ F 82 061-12-6665 Director Yrs. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a State 10c. City, Town or Location item 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event, the Madical Examinar must be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No NJ Hudson Jersey City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 A Lexington Avenue 07304 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Aves 2 No 1945 to If Yes. Give 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 TYYes 2 □ No Spaniard 3 Widowed 4 □ Divorced 1942 Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) other than " Elementary/Secondary (0-12) College (1-4or 5+) Teamster Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Emilio Neira Maria Abuendo ု့ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Paula M. Neira (daughter 12419 Canfield Lane Bowie, Maryland 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o = 0 Department of Important: If any injury or once. 14 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 10/20/2004 Alexandria, VA 21. Signature of Funeral Service Licensee. 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Brain Metastases disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cancer of the Lung Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last burial-transit Hospital or Attanding Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Vas 241No 1 Yes 1 Yes 2∏ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 1 hters Certification: To 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient this 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of After 1 X Natural 5 Pending 2 Accident investigation 1 Tes 2 No Director: 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) e Funeral Direct 4 | Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) aam O. Ullety D23743 Oct. 19, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz 7525 Greenway Ct., Greenbelt, MD 31. Date filed (Month, Day, Year) Registrar

ORIGINAL

			For Stata Registrar	State of	Maryland / Dep	artment of l	Health and M Death	Mental Hygi		34829
П	Dhuaia	:	1. Decedent's Name (First, Middle	e, Last)				2. Date of Death		3. Time of Death
	Physic /Medi		Herman L	eroy Norma	n			October	Day Ye 11, 2004	
4	Exami	ner	4a. Facility Name (If not institution	-	er)	4b. City, Town,	or Location of Death		4c. County of D	
1		~	7916 Chapel Co			Laure			Prince	George
	Funeral Director		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday 63 Yrs.	Months Days		8. Date of Birth (Month, Day,)	(ear) 9.	Birthplace (State or Foreign Country)
			241-64-0868 Usual Residence of Decedent		- 03			March 21	, 1941	N. Carolina
	yland		10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Mar Hied	to	MD Princ	e George	Laurel					1 XYes 2 □ No
	th the	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What	Country?
	23a	a	7916 Chapel Co	ve Drive		207	07		USA	
	atter dea or itama	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H	Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - A	merican Indian,
36	s atte	by Fu	1 ☐ Never Married 2 Married 2 Married 2 Married 2 Midewed 4 ☐ Divorced	ied 1 Tes 2	K] No	1 ☐ Yes 2 【XNo		riioari, oto.)	Black, W	
9	72 hours after death with the Maryland naturel', or items 23a or 28a-f show alsed Examilies must be notified at			Year or Date						Black
21215-0036	In 72	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing 16	b. Kind of Busine	ss/Industry
212	with liene.	mo	Elementary/Secondary (0-12)	College (1-4	0(5+)		nt Operato	or	Privato	Contractor
b	e tilec Il Hyg othe	a)	17. Father's Name (First, Middle,	Last)	1 4	1 4		e (First, Middle, Ma		COTICIACIOI
lar	ould by Menta narked	To B	Jess Norman				Anna Ma	ae Rawley		
Maryland	2 should be tiled within 72 hours and Mental Hygiene. Is marked other than "natural", aumatic event, the Medical Ex-		19a. Informant's Name/Relationsh	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or Rura		ity or Town, State	a, Zip Code)
	s 1 and 2 should be tiled within 72 hours atter death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, it is Medical Examilier must be notified at	١.	Jean Karen John	nson/Daught		Nathan A	Ave., Norf	olk, VA	23518	
Baltimore,	Pages 1 nent of H ant: If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from Sta	20b. Place of Dispersion	sition (Name of matory or other place	ce) I	Date 20	c. Location - City	
Ë	Pa tmen tant:		4 Donation 5 □ Other (Sp	ecify)	Skyline :	Memorial	Gdns 10/1	.6/04 Mt	t. Airy,	N. Carolina
Bal	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funeral Service L	ions	2 1 2	2. Name and Addre	ess of Facility Str	ickland E	Tuneral :	Services
	40200		Tole LX	Suck	and	6500 Alle	entown Rd,	Camp Spi	cings, M	20748
			23a. Park Enter the disease, or shock, or heart lailure. List of Immediate Cause (Final	only one cause on each	i iine.		ng, such as cardiac c	or respiratory arrest	•	Approximate Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	TIPLE MYELO	MA ————————————————————————————————————				7 Years
Р	Examiner			Due to (or	as a consequence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	b. Due to (or	as a consequence of):					
	nd nd transi	Examiner	mat mitiated events	c						
8760,	cate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to (or	as a consequence of):					
87	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical		d						
9 x	death certifica attending pt d for use as t	Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of pregnancy					
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth	2 Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of d Month	elivery Day Year
0	that the de ed by the detached	hysi	9 Unknown	9D Unknown						
S, D	es tha igned I be det	by P	Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause give	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?
ecords,	w require been sig should b							1 ☐ Yes	2 140 3 1	Probably 4 Dunknown
ecc	e law r has be je 2 sh	Completed						24a. Was an autopsy	24b. Were	autopsy findings available
		Con						performed	death's	completion of cause of
Vital	ician: certitic	Be	25. Was case referred to medical examiner?	11			26. Place of Death	(Check only one)		
of	Physician: this certitic ral director,	٦.	1 ☐ Yes 2 ☐ No 27. Mannar of Death		tient 2 ER/Outpatien	Total Control of the	4 Nursing Hon	ne 5 en sidence		ecify)
		tlon	1 ■Natural 5 □ Pending		ojury 28b. Time of Day Year) Injury	28c, Injury Work	/at k? Yes 2 □No	8d. Describe how in	njury occurred	
Division	or Attanding ifter death. Director: Atter in by the fune	fica	3 Suicide 6 Could no	ot be	njury - At home, farm, stre			SI Location /Street	and Number or 1	Bural Route Number,
S		Certification;	4 Homicide	building,	etc. (Specify)	ot, raciory, ornos		City or Town, St	ate)	surai Houte Number,
	e Hospital 24 hours a Funeral I etely tilled		29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge, death	occurred at the tim	ne, date and place, a	nd due to the cause	e(s) and manner a	s stated.
	To the Hos within 24 h To the Fur completely	ledical	one)	and manner	or examination and/or inv	estigation, in my op	oinion, death occurre	d at the time, date	and place, and du	e to the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and this of certifier	\bigcap 0	0.	29c. License			Date signed (Mor	
F	1				em.	D33224		Oc	ctober 15	5, 2004
(·k	(2)		30. Name and address of person w							
	Sta	tá	R. Trehan 50 V	32 Regis	trar's Signature		MD 20884			
	Registr		OCT 2 0 8	004 Kee	w # Apr	de				

ORIGINAL

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 34831 Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12, 2004 2004 **Physician** 03:00n Joseph Natoli /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Chestertown Queen Anne's 553 Fey Road If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Jan. 3, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F Italy 169-01-9245 91 Yrs Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits or 28e-f ehow Item 27 is marked other then "natural", or items 23a or 28e-f ehos other treumatic event, the Medical Examinar must be notified at Queen Anne's 1 Yes 2 No Director Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 553 Fey Road 21620 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Welder Fabrication 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi f Health and Menta Item 27 is marked Jean DePhillips Joseph Natoli 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ent: It Item 27 is r Judith A. Loller/Daughter 553 Fey Road, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Importent: It any injury or Chesapeake Cremation Oct.14,2004 Stevensville, MD 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility Fellows, HElfenbein & Newnam, P.A. Buk 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the dise se, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HUMAT FAILURE Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as a consequence of) The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year detached for Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ፩ signed anificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 1 Yes Hospitel or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 🔲 Yes 2 No 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 🗌 Yes 2 🗌 No investigation death 2 Accident after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature nd title of c 29c. License number ပ 10/14/04 006030/ d derson who completed cause of death (Item 33a) (Type, Brint) address of 30. Name STES, COTESTEN POUR , ND State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

2004

State of Maryland / Department of Health and Mental Hygiene 2004 3483

_		·	Certificate of Death	Reg. No.	832
	Physician	1. Decedent's Name (First, Middle, Last)		2. Dete of Death 3. Time	of Death
	/Medical	Jeannette C.	Oginz		:50AM
	Examiner	4a Fecility Name (If not institution, give street end number) Suburban Hospital	4b. City, Town, or Loc Bethesda	, and a second	
	Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. la			te or Foreign
	Director	019-01-4013 1□M 2√F 90	Yrs. Months Deys Hours Min.	8. Date of Birth (Month, Day, Yeer) AUG. 16, 1914 Massacht	usetts
_	Ď ,	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City			
	feryle r show		, Town or Location		City Limits es 2 ☐ No
	the N	Maryland Montgomery 10e. Street end Number	Rockville 10f. Zip Code	10g. Citizen of What Country?	
	3ª or	6111 Montrose Road #207	20852	United States of A	America
	be filed within 72 hours after death with the Me lel Hygiene. d other than "natural", or itema 23a or 28a-f sevent, the Medical Examiner must be notified. Be Completed by Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?	S. 13. Was Decedent of Hispenic Origin? (Specify Cuban, Mexican, Puerto R	cify Yes or No-	
2	or the	1 Never Married 2 Married 1 Yes 2 No	1 Yes 2 XNo Specify:	lican, etc.) Black, White, etc. Specify: White	
Ö	hours fural',	3 ☐ Widowed 4 ☐ Divorced Year or Dates:			
75	n name	15. Decedent's Education (Specify only highest grede completed)	16e. Decedent's Usual Occupation (Give kind of work done during most of workin, life. DO NOT use retired)	g 16b. Kind of Business/Industry	
212	d with	Elementary/Secondary (0-12) College (1-4or 5+)	Business Owner	Retail Clothes	
2	of file	17. Fether's Neme (First, Middle, Last)		(First, Middle, Maiden Surname)	
<u> </u>	Ment Ment arked	Phillip Michaelson	Mart	ha Flax	
Maryland 21215-0020	12 sh h end is m raum	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rurel		
, ,	1 end Haalt em 27	Murray Oginz - Husband 20a. Method of Disposition 20b. Pla	6111 Montrose Road #20	D7, Rockville, MD 20852 Date 20c. Location - City or Town, State	
IOI	ages ant of Series	1 N Burial 2 Cremation 3 Demoved from State C8.	metery, crematory or other place) Idean Memorial Gardens 1(
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Haath and Mentel Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be multiped at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licensee	Edward Sage1 Funeral		
ñ	Depa Impo any is	Mil	1091 Rockville Pike,		
		23a Part Ferer the disease, or complications that caused the death.		respiratory arrest, Approxim	nate
	Physician			Onset en	d Death
N	Examiner	Immediate Cause (Final disease or condition resulting in death)	OBSTRUCTIVE PULL	1011 ARY DISTAGE	
Z			as e consequence of):		
2	ficata be executed pypysicien end strengther strengther burnel-trengther edical Examiner	b	es e consequence of):		
0 50,	The law requiras that the death certificata be executed at has been signed by the attending physicien end paga 2 should be detached for use es the bunel-trensit completed by Physician/Medical Examir	if any, leading to immediate	as a consequence oil.		
7	ata be hysici the bu	Cause (Disease or injury	as a consequence of):		
× 66	antific ding p	d	2	of the	
tt. Box	that the death ce by by the attend detached for us				
0.	t tha de by the tached tached	Part II. Other significant conditions contributing to death but not result	ring in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause	
> •	s that med b e dets			1 ☐ Yes 2 No 3 ☐ Probably 4	Unknown
$\mathcal{C}_{\mathcal{A}} \mathcal{N}$	The law requires that cata has been signed to page 2 should be det Completed by P			24a. Was an autopsy performed? 24b. Were autops available prio	y findings
\mathcal{J}	has be pa 2 sho mplet			completion of death?	fcause
				1 □ Yes 2 No 1 □ Yes 2	X No
vita	ysician: The is certificata director, pag	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
Division of Vital	To lai			e 5 Residence 6 Other (Specify) Id. Describe how injury occurred	
on	ding F. Th. After the funer	27Megner of Death XINetural 5 □ Pending 28a. Date of Injury 2 Accident investigation 2 28a. Date of Injury 2 (Month, Dey Year) 2 28a. Date of Injury 2	28b. Time of 28c. Injury at 28 28c. Injury at 28 28c. 28c. Injury at 28c. In	d. Describe now injury occurred	
Visi	Attend r death ector: / by tha i	3 Suicide 6 Could not be determined 28e. Plece of Injury - At hom	ne, farm, street, factory, office 28	ff. Location (Street and Number or Rurel Route Nu	ımber,
Ö	Ital or Attending P its after death. Is Director: After t led in by the funers Certification:	4 Homicide building, etc. (Specify)		City or Town, State)	
	he Hospital in 24 hours a he Funeral plataly filled edical Ce	(Check only 2 Medical Examiner: On the besis of examination	ledge, deeth occurred et the time, date end place, an on end/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.	(s)
	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: complataly filled in by the Medical Certifical	one) and manner stated. 29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)	
	TXT8	10.44 O DALA) MAD	DI PORU	ACTIBED IC	13.611
	4	30. Name and address of person who completed cause of death (Item 2	23a) (Type Print)	000000015,2	-004
		DINESH PATELMIN.	6121 MONTROJE RI	Keckullelin 2018	-57-
8	State	31. Dete filed (Month, Day, Year) 32. Registrar's Signatu	0.11.700010.10-010	1000	1
	Registrar	OCT 19 2004 Deneral	D Docker		

		1 - For State Registrar	State of	Marylan	d / Depa	artment rtificate	of H	ealth a Death	and M	ental Hy	giene (004	348	333
		1. Decedent's Name (First, Middle, La	ıst)							2. Date of De	ath Day	V	3. Time o	f Death
Physic /Medi		Woodrow Die	h1	Orner						Octobe		Year 2004	2:05	ам
Exami		4a. Facility Name (If not institution, gi	e street and numb	oer)		4b. City, To	own, or	Location of	of Death		4c. Co	unty of Deat	h	
		405 Hillmoor Dr	ive					Sprin				ntgom	ery	
Funeral			Sex 7. 1•2 M 2 □ F	. Age (In yrs.		If Under 1 Months	Year Days	If Under:	Min	8. Date of Birt (Month, Da	h y, Year)	Co	nplace (State untry)	
Director		579-12-3946	X M Z I		86 Yrs.					Sept. 2	8, 191	8 Per	nsylva	nia
and		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside C	City Limits
dary!	٥												1 🗍 Yes	2√ No
the the 288-	Director	Maryland Montg	omery	S	ilver	10f. Zip C					10g. Citizen	of What Co	untry?	
as or	ō	405 Hillmoor D	rivo			20	901					USA		
death ms 2:	Funeral	11. Marital Status	12. Was Deced		.S. 13.	Was Decede	nt of Hi	spanic Orig	gin? (Spe	cify Yes or No	- 14.	Race - Ame		
or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Force 1			if Yes, specif 1 ☐ Yes 2[Specify:	i, Pueito i	nican, etc.)		Black, White		
Pris 1	l by	3 ☑ Widowed 4 ☐ Divorced	Year or Date	es: WW-II		10 163 21	X 140	ороспу.			ЗР	ecify: Whi	te	
tiled within 72 hours after death with the Maryland Hygiene. Hygiene and a start or Items 23a or 28a-f show out, the Medical Examination collined at	Completed	15. Decedent's E (Specify only highest gi			(Give	dent's Usual kind of work	done a	turing most	of working	ng .	16b. Kind	of Business/	Industry	
Mithin Nethin	mpi	Elementary/Secondary (0-12)	College (1-4	tor 5+)		DO NOT use					C-	1£ E	hours I.	
iled v dygie her t	ပိ	12 17. Father's Name (First, Middle, Las	<i>t</i>)	-	Ма	sonry	Con			(First, Middle,		lf Emp	тоуеа	
at be f	Be	Harry J. Orner	·/							. Diehl		,		
Idn yidnin ZIZIOOOO 2 should be filed within 72 hours after death wi and Mental Hygiene. Is marked other than "natural", or Items 23a- aumatic event, the Medical Examiner musts	To	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a			i Route Numbe		wn, State, 2	lip Code)	
and 2 s and 2 s ealth ar n 27 le		Caroline H. Orne		-02	906	S Ma	chi	naton	C+	#201,	Maya	ndria	VA 22	314
t Hear		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name	e of		D	ate		on - City or		JII
Pages nent of nr; if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec		tate	Metropo Crema		or piac	J 10	200	er 18 04	Alexa	ndria,	Virgi	nia
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatto event, the Medical Examinational be notified at any injury or patter traumatto event, the Medical Examinational Benchilded at once.		21. Signature of Funeral Service Lice			2:	. Name and								
g age ag		(inches)	4(1)	le	5	rancıs 00 Uni	ver:	sity	Blvd	Funeral , W, Si	lver		ng, MD	20901
		23a. Part1. Enter the disease, or cor shock, or heart failure. List only	nplications that cau	used the deat	h. Do not en	er the mode	of dying	g, such as	cardiac o	r respiratory ar	rest,		Approxima Interval Be	tween
Physician	į	Immediate Cause (Final disease or condition	9										Onset and	
/Medical		resulting in death)	a. <u>Sepsi</u> Due to (o	ras a conseq	(uence of):						~		72 nou	.15
Examiner		Sequentially list conditions.	b											
p ii	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	r as a conseq	(uence of):							ĺ		
ecute and I-tran	кап	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	uence of):									
cate be executed physicien and the burial-transit	70				,, -									
OK CO (COU), certificate be executed nding physicien and use as the burial-transit	응		d											
wrequires that the death certific been signed by the attending p should be detached for use as is	ician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco			-					23d.	Date of deli	very	
death death death death death death	cial	in the past 12 months?	4□Pregna	th 2 □Feta nt at time of d		Ectopic pred Other (spe						Month	Day	Year
oy the ache	hys	9 Unknown	9□ Unknov	vn										
requires that the seen signed by the hould be detached	by P	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the u	nderlying car	use give	en in Part I.		23e. Did to	bacco use		the cause of	
w requires to been signed should be	ed	Neurogenic Bladd	er							1 🗆 \	∕es 2½√.N	o 3 □ Pr	obably 4 🗆	Unknown
2 S S	ompieted									24a. Was	sy	4b. Were au	topsy findings	available cause of
Th Th	Com										rmed? 2 🔀 No	death?	2□ No	
Physician: The Properties of t	Be (25. Was case referred to medical examiner?							of Death	(Check only o	ne)			
Physic rthis corral dire	10	1 ☐ Yes 2 ☑ No			ER/Outpatie			4 🗆 140		ne 5 Resid			cify)	
ding P	lon:	27. Manner of Death 1 Natural 5 Pending	28a. Date of (Month)	, Day Year)	28b. Time o	M 28	C. Injury Work	/at <br Yes 2 □ I		8d. Describe t	iow injury oc	curred		
Sicological Sicolo	cat	2 Accident investigati 3 Suicide 6 Could not	be 380 Blace o	of Injury - At h	omo farm et			165 2		28f. Location (5	Street and N	umber or Ru	rai Route Nun	nher
To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	4 Homicide determine	building	g, etc. (Special	fy)	eet, factory,	OHIOG			City or Tov				,
spital ours a neral filled		29a. Certifier 1K Certifying F	hysician: To the b	est of my kno	owledge, deat	h occurred at	t the tim	ne, date an	d place, a	and due to the	cause(s) and	d manner as	stated.	
To the Hos within 24 h To the Fur completely	edical		miner: On the bas and manne	sis of examina										5)
of the somple	Me	29b. Signature and title of certifier				29c.	License	o number			29d. Date si	gned (Montl	n, Day, Year)	
10.41		I full be	Jok, no				D22	309			Octob	er 18,	2004	
, (30. Name and address of person wh	completed cause	of death (Iter										
		Phillip Poth,				e., Si	lve	r Spr	ing,	MD 209	01			
	tate	31. Date filed (Month, Day, Year)	//.	gistrar's Signa	ature	Span	Kal	,						
Regis	ırar	OCT 19 20	04		1	1								

			1 - For State Registrar	State of M	laryland / Depa <i>Cei</i>	artment of F			giene		34834
1			1. Decedent's Name (First, Middle,	, Last)				2. Date of De			3. Time of Death
	Physici /Media		Donald H	Bubert 1	Pyle, Sr.			October	13	2004	7:15 a. M
	Examir		4a. Facility Name (If not institution,			4b. City, Town, o	Location of Death			County of Death	
			North Arundel H	Hospital		Glen Bur				ne Aruno	
	Funeral	-		6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th		place (State or Foreign ntry)
	Director		218-14-2366	M2□F	79 Yrs.	Months Days	Hours Min.	(Month, Da	y, Year)	925 Mary	ntry)
	pr ,		Usual Residence of Decedent								Tana
	show	_	10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits
	Be-f	cto	-	Arundel	Severn						1 □ Yes 2 元No
	dith th	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citi	zen of What Cou	ntry?
	ath v	œ	8114 Spaulding	Circle		2114	14		Unit	ed State	es
	tems	n n	11. Marital Status	12. Was Decedent Amed Forces	?	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No Rican, etc.)		14. Race - Ameri Black, White,	
36	s efte	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	IS Was Cities	No 11_15_43	∏Yes 2√∑ No	Specify:			Specify: Whi	
21215-0036	within 72 hours effer death with the Maryland ene. than "natural", or items 23a or 28e-f show the Madical Examiner must be notified at	be De				Landa III. III.					
15	n 72	lete	15. Decedent' (Specify only highest	grade completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of work	king		nd of Business/In Y Scouts	
12	with ene.	Completed	Elementary/Secondary (0-12)	College (1-4or	3+)	rector	,			y Scouts erica	O.L
9	be filed within 72 hours efter death with the Maryla Ital Hygiene. Id other than "natural", or items 23a or 28e-f show event, It a Madical Examiner must be mutilled at		17. Father's Name (First, Middle, L	.ast)		1	18. Mother's Nam	ne (First, Middle,			
an	d be ental ked c	To Be	Howard V. Pyle					e V. Ke			
Maryland	s 1 and 2 should be filed withing Hoglene. If Heelth and Mental Hygiene. Item 27 is marked other than other traumatic event, Ine M	-	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mailin	g Address (Street a				Town State Zir	(Code)
Ž	12 E		Iris D. Pyle	(wife)		Spaulding					
<u>a</u>	is 1 and 2 of Heelth item 27 i		20a. Method of Disposition	(220)	20b. Place of Dispos cemetery, crem	sition (Name of	CITCLE	Date Date		cation - City or To	
9	Pages nent of I ant: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp.		Maryland V		_ 0000	ber 18,			, Maryland
Baltimore,			21. Signature of Funer Service L					04	CLO	MIIZATITE	, Maryland
ä	permit. Departr Imports any inju		- Pala		M00982 83	l4 Bestga	te Rd. A	ams rune nnapolis	eraı s. Ma	& Crema ervland	tion Care
			23a. Parti. Enter the disease, or d	complications that cause	d the death. Do not ente					az j zuma	Approximate
	Fnysician		Immediate Cause (Final	inly one cause on each i	ine.						Interval Between Onset and Death
	/Medical	11	disease or condition resulting in death)	a	a consequence of):	ial N	tactro	DN			1 HOUN
	Examiner				Contractor of the	. Koni	farction of Orsain				1.0
	-	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	1 сопвечиниее от.	reco	7 073000	7	-		2 years
	outed d ansit	Examiner	Cause (Disease or injury that initiated events		Actions	Externo 1					20 years
0,	an ar		resulting in death) Last	Due to (or as	a consequence of):						Terro
8760,	death certificate be executed e attending physician and od for use as the burial-transit	dlcal	1	d						-	
9	ntifica ng ph as th	Med	15.55141.5								
Вох	death certifica attending ph d for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnancy			2	3d. Date of delive	ry
	dea death	scl	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant a 9□Unknown		Other (specify)				Month	Day Year
P.0	at the de by the	hy	9 🗌 Unknown								
	law requires that the as been signed by th 2 should be detache	by l	Part II. Other significant condition	is contributing to death b	out not resulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco us	se contribute to th	e cause of death?
ord	w requir been si should							1 🗆 Y	es 2 🗷	Mo 3□ Prob	ably 4 Unknown
of Vital Records,	e taw r has be	ompleted						24a. Was a		24b. Were auto	osy findings available
E	Th ate pag	Соп						perfor	med? 2.☑No	death?	2 No
ita	Physician: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Deat				
>	S S T	2	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	ent 2 P/Outpatient	3□ DOA Othe	r: 4 🗆 Nursing Ho	me 5 Resid	ence 6	☐Other (Specify	,)
0			27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 28b. Time of Injury	28c. Injury Work		28d. Describe h			
Sio	Attending or death, ector: After by the fune	atl	2 ☐ Accident investiga	ation			′es 2 □No				
Division	after death after death Director: I in by the	Certlfication:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (S. City or Town	treet and n, State)	Number or Rura	Route Number,
	urs af			4							
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the best xeminer: On the basis o	t examination and/or invi	occurred at the timestigation, in my op	e, date and place, inion, death occur	and due to the c	ause(s) a late and r	and manner as st	ated. the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and mainer st	ated.						
•	5 ½ ½ 5) ((10) A	- 10000	112	V	number	2	Ju. Date	signed (Month, I	vay, rear)
,			, we	seci 7	110	#1	1744		10	113/04	
			30. Name and address of person w	the completed cause of d	leath (Item 23a) (Type, F	nint)	600-	Sucka	1 : -	62.	
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	o nosp	TECT UT:	11-6	11	e J, n	21061
	Registr	ar	061 [;	2004	Jeath (Item 23a) (Type, F 147 2 3 g ar's Signature	bosti					

DHMH 17 Rev 1/2001

Registrar

9 2004

			For State Registrer	State of M	laryland	-		nt of H		nd Me		giene Reg. No	1006	31.	836
		2	Decedent's Name (First, Middle, La.	st)							2. Date of Dea	ath	-00	3. Time	of Death
	Physicia /Medic		Ida Pompilia Pag	e						0	otober	15,	200 ^{Year}	5:4	0 P M
2	Examin		4a. Facility Name (If not institution, give	e street and number)		_		Location of	Death			County of Dea		
9. · · ·		-0-	Casey House					svill		400-			ntgome:		
	Funeral		5. Social Security Number 6. S	ex 7. A ☐ M 2		ast birthday) Yrs.	Months	r 1 Year Days	If Under 24 Hours	Min.	3. Date of Birt (Month, Da	y, Year)		rthplace (State ountry)	
Н	Director	}	Usual Residence of Decedent		91	110.]		Mg	ay 14,	191	3	NY	-
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Limits
	Many -fsh fied	to	MD Montgo	mery	S	ilver	Spri	ng						1 📉 Ye	s 2 No
	r 288	Director	10e. Street and Number				10f. Zi	p Code				10g. Citi	zen of What C	country?	
	th wit		3701 Internationa	1 Drive			2	0906				US	A		
	within 72 hours after death with the Maryland ane. then "naturel", or Items 23s or 28a-f show the Medical Evantrer must be rediffed at	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S	S. 13. \	Was Dece f Yes, spe	dent of His	spanic Origi n, Mexican,	in? (Speci Puerto Ri	ify Yes or No- ican, etc.)	-	14. Race - Am Black, Wh		
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2X If Yes, Give			1 🗌 Yes	2 ⊠ No	Specity:				Specify: Wh	ite	
Ö	hours turel'		3 Nidowed 4 Divorced 15. Decedent's E	Year or Dates:		16a. Deced	iont's Lie	al Occupa	tion			16h Ki	nd of Busines		
<u> </u>	in 72	Completed	(Specify only highest gra	de completed)		(Give	kind of w	ork done d ise retired)	urina most o	of working	9	TOD. IXI	na or basines.	williaustry	
712	iene.	mo	Elementary/Secondary (0-12)	College (1-4or	5+)	Secre	tarv					Ci	ty Gove	ernment	
b	illec I Hyg other	a)	17. Father's Name (First, Middle, Last,)					18. Mother	's Name (First, Middle.			-	
a	Alenta Alenta rked tic ev	To B	Joseph Celli						Lind	a Sor	nsini				
lary	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "naturel", or Items 23e or 28a-f show is marked other than "naturel", or Items 23e or 28a-f show reumatic event, it a Medical Eran it er in a the notified at		19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	g Addres	s (Street a	nd Number	or Rural I	Route Numbe	er, City o	r Town, State,	Zip Code)	
Σ.	and and and and and and and and and and		Edward A. Page /	Son	000 00				on Pa				gton, I		5
ore	of H		20a. Method of Disposition 1 ☐ Burial 2 💆 Cremation 3 ☐	Removal from State	206. PI	lace of Dispo emetery, cren	sition (Na natory or	me of other place) Oc	ctobe			cation - City o		
Ë	tment tent:		'4 □ Donation 5 □ Other (Specif	y)		ropoli				2004		A1e	xandri	a, VA	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic events.		21. Signature of Funeral Service Licer	Isee A					s of Facility Colli		uneral	Hom	e, Inc		
	40100		23a. Part1. Enter the disease, or com	plications that cause	od the death	50	<u>O Uni</u>	vers	Lty_Bo	ulev	ard W.	, Si	lver S	pring,	
			shock, or heart failure. List only	one cause on each	line.	. Do not sint	or the mo	ao or aying	, 30011 03 01	ardiac or r	rospiratory ar	1631,		Interval Bo Onset and	etween
}	Physician /Medical		disease or condition resulting in death)	a. Acute			<u>kemi</u>	ā			-				
	Examiner			Due to (or as											
£.	, sa	er	Sequentially list conditions, if any, leading to immediate	b. Myelod: Due to (or a	ysplas s a consequ	stic Sience of):	yndr	ome							
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C											
oʻ	sician and burial-transit	Exa	resulting in death) Last	Due to (or as	s a consequ	ience of):									
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After the completely filled in by the funeral	Medical		nysician: To the best niner: On the basis of and manner s	of examinat										(s)
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	6) CK/	$\overline{}$				03563	5		(Octol	per 16,	2004	
	U		30. Name and address of person who	completed cause of	death (Item	23a) (Type	D=i=4\								
		- 1	So. Hamo and address of person who	completed cadde at	acami (mo		Print)								
_			Joseph Kaplan, M	1.D., 60		incaste	er Mi	11 Ro		Rockv	ille,	MD 2	0855		

State of Maryland / Department of Health and Mental Hygiene 00 L 34837 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 15 2004 October 9:10 p^M d /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ctr Carroll Lutheran Village Heath Care Westminster Carroll If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 **X**M 2 □ F 63 August 27 1915 Director 549-34-4727 Conn Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits rai', or items 23a or 28e-f shov Exar, ther must be notified at 1⊠Yes 2 No Director MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 300 St. Luke Circle 21158 USA death Funeral permit Pages 1 and 2 should be filed within 72 hours effer death Department of Health and Mental Hygiene. Importent: if then 27 is marked other the any hours or other trainment. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White ğ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry
Social Security (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Administration Claims Adjustor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Felicianna Fusco Luigi Palaia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Palaia/son 118 Willis Street Westminster, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Carroll Cremation, Inc ' 4 ☐ Donation 5 ☐ Other (Specify) 10/18/2004 Hampstead, MD Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumenic +snivceture /Medical Due to (or as a consequence of) Examiner DP13 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year -Day 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 6 ERY 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate 2 No To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) this d in by the funeral d 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours e To the Funerel I 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and marmer stated. death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) .7 asilins Aberounder Busc 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 1 8 2004 Registrar Goods

State of Maryland / Department of Health and Mental Hygien 200 [34838 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Mary Puma October 1:30 a^M 15 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death at Westminster Summerville Westminster Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Months Days Hours Director 113-03-0566 85 Jan 03 1919 Easton, PA Usual Residence of Decedent deeth with the Maryland 10a State show 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event. Its Machical Examinar must be notified at MD Carroll Westminster 1 ☐ Yes 2 XNo Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1404 Chazadale Way 21157 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify: 3

Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Milford Board of d 2 should be filed within 7. Ih and Mental Hygiene." In 7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) Education 8 Dietician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Muriano Lena Calzone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is 1 and 2 s if Health an item 27 is Denise Wheeler/daughter 1404 Chazadale Way Westminster, MD 21157 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If ites
any injury or ott 1 Burial 2 Cremation 3 Removal from State Garden of Memories 10/19/2004 Tampa, Florida * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** stire disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medicai 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ peq 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No certificate 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IM D051705 nmorth 10/15/2004 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster, MD 21157 349 DR PANSURIYA malwim 31. Date filed (Month, Day, Year) 32. Registray's Signature State 8 2004 Registrar

Michael S. Plowman 04-6949

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

04-6949 AKG	-	1 - State Unpend Item Registrar	State of Ma 23a, 27, 28a	aryland/ a-f per	Depar me G Certi	tment (1838 I ficate	of Health ar 2-8-04 to of Death	nd Mental H as	lygiene Reg. No	2004	34839
Physicia	_	1. Decedent's Name (First, Middle, Las	t)					2. Date of I Month			3. Time of Death
Physicial /Medica		Michael Scott Pl	.owman					Octol		17, 2004	
Examine	er	4a. Facility Name (If not institution, give			i		wn, or Location of I	Death		. County of De	
9-		Northwest Regiona 5. Social Security Number 6. Se] e (In yrs. last i		Randa] If Under 1 Y	Llstown Gear If Under 24	Hrs. O. Davis and			re County
Funeral Director			FWM 2□F	26		Months D		Min. 8. Date of E	Dav. Yearl	1978 ^{9. 8}	irthplace (State or Foreign Country)
3		Usual Residence of Decedent		26				Oct.	20, 1	1970]	PA
trylan	_	10a. State 10b. County		10c. City, To	wn or Loca	tion					10d. Inside City Limits
8e-f s	Director	MD Washingt	on	Casca	ade						1 ☐ Yes 🏋 ☑ No
with the	2	10e. Street and Number				10f. Zip Co				tizen of What C	country?
death with the Maryland ms 23e or 28e-f show rmust be notified at	Funeral	25323 Cherry Lar	IE 12. Was Decedent I	Ever in I.I.S.	13 Wa		1719	2 (Chooity Voc or I		JSA 14. Race - Am	andren Indian
of the ritter	5	1 Never Married 2 Married	Armed Forces? 1 □Yes 2 □ N If Yes, Give		lt Y	es, specify	Cuban, Mexican, F	? (Specify Yes or I uerto Rican, etc.)	40-	Black, Wh	
O36	2	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1	Yes 20	No Specify:			Specify: wh	hite
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ld be ental	o Re	Alexander S. Pl	OI 777 O.D.					n Marie I		,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23e or 28e-1 show any injury or other treumetic event, the Modical Examinar must be notified at once.		19a. Informant's Name/Relationship (7		19	9b. Mailing A	Address (St		or Rural Route Num			Zip Code)
, Mand 2 and 2 saith a 27 is		Alexander S. Pl	owman fatl	her	P.O.	Box 5	67 Blue	Ridge Sur	nmit	PA 1721	14
Baltimore, semit. Pages 1 ar Department of Hea mportent: If item iny injury or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place cemet	of Dispositi tery, cremat	on (Name o	of	Date		ocation - City o	
Lim Pag ment fent: I		`4 □Donation 5 □ Other (Specify		Bethe1	Chur	ch Ce	em. No	v. 2, 200)4 Ca	scade M	4D 21719
Balf permit Depart Import any in		21. Signature of Funeral Service Licens	1 1 1		22. N	ame and A	ddress of Facility				eral Home, In
_ 402.64	1	330 Port 5 to the disease of the	Money	the death D	50	S. Br	oad Stre	et Waynes	sboro	PA 172	268
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On On ding It.		1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year)	Injury	Z00. I	njury at Work? 1 □ Yes 2 👿 No	280. Describe	now injury	y occurred 1	lik.
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Div tel or rs afte el Dir ed in t		4 Homicide determined	Auto	. (Specity)				Baltimo	iwn, State,) 1-70 W	Vest&695
		29a. Certifier (Check only (Check only 2 Medical Exami	sician: To the best o	f my knowledg	ge, death oc	curred at th	e time, date and p	ace and due to the	(a) cause/s	and manner as	s stated.
the Hosp nin 24 hou the Fune npletely fil			ner: On the basis of and manner stat	led.	III WO III WOSI			ccurred at the time	, date and	place, and due	to the cause(s)
To To com	3	29b. Signature and this of certifier				29c. Lic	ense number		29d. Date	e signed (Mont	h, Day, Year)
	-	1 Cork	em)				.C.M.E.		Octo	ober 27	, 2004
		30. Name and address of person who co	week of de	(Item 23a)			enn Stre	et, Balti	more,	Maryla	and 21201
State Registrar		31. Date filed (Month Cay, Year) 0 3 2(32. Registra	r's Signature	1.						

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar		laryland / De	partment of ertificate of	Health a Death	and Mental Hy	Heg. No.	04	34840
	Physici /Medi			er PECK				2. Date of D Month	Day	Year 2004	3. Time of Death 3:30 P
	Examir Funeral Director	ner	3., 1032	1	ge (In yrs. last birthd. 84 Yrs	Months Dave	esda r IfUnder2	24 Hrs. 8. Date of B Min. (Month, D	Mo	nty of Death ntgome 9. Birth Cou	e ry eplace (State or Foreign intry)
	show	ž	Usual Residence of Decedent 10a. State 10b. County Marry Land Monto	000000	10c. City, Town or	Location					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the N 23a or 28a-f st be notifia	Funeral Director	Maryland Montg 10e. Street and Number 10809 Georgia Ave		Wile	10f. Zip Code 209	902		10g. Citizen United		intry?
980	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Modical Examirer must be multimed at	by Funer	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	? No	3. Was Decedent of If Yes, specify Cult		gin? (Specify Yes or N Puerto Rican, etc.)		Race - Americ Black, White,	, etc.
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nd 21	be filed wi ta! Hygien d other th event, Ire	Be	17. Father's Name (First, Middle, Last)	2	Reg	gistered N	18. Mother	's Name <i>(First, Middle</i> Sarah Frank	, Maiden Surr	ursing	5
Maryland 21215-0036	2 should and Mer is marke sumatic	2	19a. Informant's Name/Relationship (Shari Shor, Niece	Type, Print)	19b. Ma		t and Number	r or Rural Route Numb	er, City or To		o Code)
Baltimore,	permit, Pages 1 and 3 Department of Health Important: If item 27 any injury or other tri		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		20b. Place of Dis	sposition (Name of rematory or other pla	ace)	Date	20c. Locatio	n - City or To	
Balti	permit. Pages Department of Himportant: If ite any injury or of once.		21. Signal up of Furteral tervice Lear	SAA		22. Name and Addr	ess of Facility	Tuneral	Ното		9012
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O. Box	requires that the death certiticate een signed by the attending phy; nould be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	a	2 Fetal death	B Ectopic pregnanc 5 Other (specify)	ey .			Date of delive	ery Day Year
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	2 7 2 5 4	_	29b. Signature and title of certifier	(no	//_		6046		29d. Date sign		Jay, Year)
			John J./Merendin	o Jr., M/		•	Road,	#405, Beth	esda, 1	1D 20	817
	Sta Registr		31. Date filed (Menth, Day, Year) OCT 18 20		ar's Signature	Spark					

State of Maryland / Department of Health and Mental Hygienes 1 - For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 14, 2004 Harvey David Poster 10:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 15103 Nashua Lane Prince Georges Bowie | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | 9. Birthplace (State or Fore Country) | Pennsylvania 6. Sex 1 ★ M 2 ☐ F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Yrs. Director 118-32-2460 61 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Mailcal Examiner mant be natified at 10d. Inside City Limits Maryland Prince Georges Bowie Director 1 ☐ Yes 2 ☑ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 20716 15103 Nashua Lane United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 □ No If Yes, Give Year or Dates: 1965 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Office Supplies Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 Is marked any injury or other traumatic evenes. Milton Poster Edith Batnick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15103 Nashua Lane, Bowie, MD 20716 Danna Poster, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State IX Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Lebanon Cemetery 10/17/04 4 □ Donation 5 □ Other (Specify) Adelphi, MD 21. Signature of Funeral Service Torchinsky Hebrew Funeral Home 23a. Part I. Enter the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 254 Carroll St., NW. Washington, DC 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Eschageal **Physician** (ancer 15 mentles disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medlcal IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 No 1 Yes 2 No 1 🗌 Yes To the Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 15,2004 D50343 October 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #201, Bown, Marylard 20716 14999 MD Health (enter 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State 18 2004 Registrar OCT

W			1 - For Unpend Item Registrar	23a&27 pe	larylan r me	37ena Cer	rtment of tificate o	Health of Deat	and M h	ental Hy	giene 0	04	34842
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4	Examir	er	4a. Facility Name (If not institution, giv			410	4b. City, Town		n of Death			y of Death	
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	th the or 28a enoti	lirec	10e. Street and Number				10f. Zip Code	9			10g. Citizen of	What Cour	ntry?
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Baltimore, Maryland 21215-0036	72 hours after death with the Maryland natural', or Items 23a or 28a-f ehow deal Examiliar must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ₹ If Yes, Give Year or Dates	?] No		Vas Decedent of f Yes, specify C □ Yes 2⊠ N			city Yes or No Rican, etc.)		ce - Americ ck, White, fy: Asi	etc.
5-0	72 hours "natural", vical Exe	etec	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Deced	lent's Usual Occ kind of work do DO NOT use ret	cupation ne during me	ost of workir	ng	16b. Kind of B	usiness/In	dustry
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nor	ages fr: Fig		1 ☐ Burial 2 【▼ Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Special		e ce	emetery, cren	natory or other p					-	Maryland
altir	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Itam 27 Ie marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Lice		ror	1,22	Name and Add	dress of Fac	y 10/3	50/2004	brentw	ooa,	Maryland
ä	90 4 40		Noncy A.	Vercent	re	<u>T</u> T	800 New	Hamp:	<u>shire</u>	Ave, S	Silver S	pring	MD 20904
J	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that cause one cause on each Acute a	_	n. Do not ente	er the mode of d	lying, such a	as cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	uence of):							
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.O. Box 6	The law requires that the death certif te has been signed by the attending tage 2 should be detached for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 Fetal	death 3	Ectopic pregnal Other (specify)					ate of delive	ery Day Year
<u>α</u>	s that the ned by detacts	by Ph	Part II. Dther significant conditions	contributing to death	but not resu	ulting in the un	derlying cause	given in Pari	t I.	23e. Did t	obacco use cont	tribute to th	ne cause of death?
rds	w requires been sign should be	ed b								1 🗆 `	Yes 2□No	3 🗌 Prob	ably 4 Unknown
of Vital Records,	The law re cate has be page 2 sho	Completed								24a. Was	Dsy	Were autor prior to cor death?	psy findings available mpletion of cause of
a	. 49 07		25. Was case referred to medical							1 Yes	2 No		2□ No
<u> </u>	Attending Physician: r death. ector: After this certific by the funeral director.	To Be	examiner?	Hospital: 1 ☐ Inpat	ient 2 🗆 I	ER/Outpatient	3 □ DOA C	N		(Check only o		er (Specifi	at scene
n 01	ding Phi h. After thi funeral		27. Manner of Death 1 Natural 5 Pending	28a. Date of In (Month, D		28b. Time of	28c. In				how injury occur		de scene
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Division	tal or Attences effer death	Certification;	4 Homicide determined	286. Place of II	njury - At ho etc. <i>(Specify</i>	me, farm, stre	et, factory, offic	:8	2	8f. Location (S City or Tov	Street and Numb wn, State)	er or Rura	l Route Number,
	To the Hospital or Atte within 24 hours efter de To the Funaral Directo completely filled in by th	edical	29a. Certifier 1 Certifying Pt (Check only one)	ysicien: To the bes niner: On the basis and manner s	of examinat	wledge, death ion and/or inv	occurred at the estigation, in my	time, date a y opinion, de	and place, areath occurre	nd due to the d at the time,	cause(s) and ma date and place,	inner as stand due to	ated. the cause(s)
	To the within 2 To the complei	Σ	29b. Signature and title of certifier	1 /2			29c. Lice	nse number			29d. Date signe	d (Month, l	Day, Year)
			Thusling	11.16	X-	w)	oa	ME		(October	25	2004
			30. Name and address of person who		death (Item								
	Sta	te	31. Date filed (Month, Day, Year)		trar's Signat	ure /	Penn S	treet	, Bal	timore,	, Maryla	nd 21	1201
	Registr	ar	OCT 27 20	14 Den	wa	19	Doark	21					

State of Maryland / Department of Health and Mental Hygiene 2004 For State Ragistrar 34843 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** OCTOBER 11, NANCY GRACE REID 8:15 A^M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 310 BAY CITY ROAD STEVENSVILLE QUEEN ANNE'S If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Davs | Hours | Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🗶 F Yrs Director 38 118-60-1810 APR. 6, 1966 **NEW YORK** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r Items 23s or 28s-f show 10d. Inside City Limits 1 ☐ Yes 2 No MD QUEEN ANNE'S STEVENSVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 310 BAY CITY ROAD 21666 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Funeral 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married ō altimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: þ WHITE 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER ACCOUNTING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JOSEPH CRANE ROSE MARY PRICE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health at: If item 27 is ROBERT RYAN REID/HUSBAND 310 BAY CITY ROAD, STEVENSVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY 10/12/2004 STEVENSVILLE, MD 21. Signature of Fuperal Service Licensee Name and Address of Facilit FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part I. Enter the disease, or complications, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one capital and line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** BREBST CANCER disease or condition resulting in death) me /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine the death certificate be executed attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2.6 No 9 ☐ Unknown detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 8 2 No 1 Tes 3 Probably 4 □Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 has autopsy performed? 1 Yes 2/0(No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel within 24 hours To the Funerel 122 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2004 30. Name and address of person who, completed cause of death (Item 23a) (Type, Print) BESTGATE RD PANNAGELS MOZ1401 NATKINS Vn MANLEY 900 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

		1 - For State Registrar	State of Mar	yland / Depa <i>Ce</i>	artment of rtificate of	Health and Death		Heg. No.	004	3484
Physic /Medi		1. Decedent's Name (First, Middle, Last Frances Clarabell		Alohan			2. Date of D Month Oct.	15, Day	004 Year	3. Time of Death /0:30PM
Examir	ner	4a. Facility Name (If not institution, give 158 Colony Road A	pt. C		Silver			Mon	tgomer	
Funeral Director		5. Social Security Number 6. Se 051–40–6838 Usual Residence of Decedent	7. Age (In yrs. last birthday) Yrs.	If Under 1 Yea Months Days			ay, Year)		lace (State or Foreig try) York
Permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Page 1. The Medical Existing Franch 23 or 28e-f show in yinjury or other treumatic event. It a Medical Existing franch to notified at 200.	leted by Funeral Director	10a. State 10b. County MD Montgome 10e. Street and Number 158 Colony Road Ap 11. Marital Status 1 Never Married 2 Marned 3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grad	2. T.y 12. Was Decedent Ev. Armed Forces? 1	16a. Dece	20903 Was Decedent of If Yes, specify Cu	upation e during most of w		US 0- 14.	of What Coun	an Indian, atc. 2 k
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should be file and Mental Hyg marked othe umatic event,	To Be C	17. Father's Name (First, Middle, Last) Rupert Rattigan			F		ame (First, Middle a Ballar	, Maiden Sur	name)	-
s 1 and 2 should if Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (T) Avize Sabater Son				at and Number or F	Rural Route Numb	er, City or To	wn, State, Zip	
Pages 1 and 2 ment of Health ont: If item 27 ary or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	lemoval from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other pla	1	Date	20c. Location	on - City or To	wn, State
permit. Pages Department of Importent: If it any injury or o		4 ☐ Original on 5 ☐ Other (Specify) 21. Signature of Funeral Service Liceas		Frederic 22		ess of Facility Language				
Physician /Medical Examiner	6	23a. Part1. Enter the disease, or compishock or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Carcino Due to (or as a c	oma of The consequence of):		ing, such as cardia	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
requires that the death certificate be executed een signed by the attending physicien and nould be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, Lary leading to mindrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c							
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To the Hospitel or Attending Physicien: Th within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director. pag	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	lospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursing I	Home 5 ArResi 28d. Describe	dence 6 🗆 0		
tel or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (· At home, farm, stre Specify)	eet, factory, office		28f. Location (City or To	Street and Nu wn, State)	mber or Rural	Route Number,
To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of mer: On the basis of ex and manner stated	amination and/or inv	occurred at the trestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) and date and plac	manner as sta e, and due to t	ited. the cause(s)
To t Vithi Comp	W	29b. Signature and title of certifier	Checha	lm MD	29c. Licen	25/6			ned (Month, D	
(3)		30. Name and address of person who co			Print)					
Sta Registr	1	Reginald Chisolm 31. Date filed (Month, Day, Year) OCT 2 0 2004		ia Avenue Signature	N. W.	washingt	on, D.C.	2000		

1 - For State Registrer

	- 16	Decedent's Name (First, Middle, Last)								2. Date of Death Month	Day	Year	3. Time of	Death
Physici: /Medic		Maria M. Repole								October			4:47	a M
Examin		4a. Facility Name (If not institution, give stree	and number)		4	4b. City, To	own, or	Location o	f Death		4c. County	of Death		
		7446 Morrison Drive						belt			Princ	e Geo	rge's	
Funeral		5. Social Security Number 6. Sex		78		If Under 1 Months	Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day,	Year)	Cour		or Foreign
Director		088-40-1051 Usual Residence of Decedent		/0	113.					July 14,	1926	Ital	-У	
land ow		10a. State 10b. County		10c. City, Town	or Locat	tion				,, -, -, -, -, -, -, -, -, -, -, -, -, -		1	0d. Inside C	ity Limits
Mary -f sh	ţo	Maryland Prince Geor	ge's	Gree	nhe1	t							1 🌠 Yes	2 🗆 No
r 28a	Director	10e. Street and Number	BC 0	Office	IIDCI	10f. Zip C	Code			10	g. Citizen of	What Cour	ntry?	
h with	ai D	7446 Morrison Drive					207	70			U.S.A			
deat	Funerai	11. Marital Status	/as Decedent E	Ever in U.S.	13. Wa	as Decede	nt of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14. Rad		an Indian,	
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n 72 I	iete	15. Decedent's Educatio (Specify only highest grade cor		16a.	(Give kin	nt's Usual nd of work NOT use	doné d	uring most	of workir	ng 1	6b. Kind of B	usiness/In	dustry	
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of He fiten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 X Remo	val from State	20b. Place of cemeter	Dispositi y, cremat	ion (Name tory or oth	e of er place	9)	D	ate 2	0c. Location	City or To	wn, State	
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permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licensee		0 -						ch's Fur		-		
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		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ns that caused use on each lin	the death. Do n ie.	ot enter 1	the mode	of dying	, such as	cardiac o	r respiratory arres	st,		Approximat Interval Bet Onset and	ween
Physician		Immediate Cause (Final disease or condition resulting in death)		tic Ader		rcino	ma							
/Medical Examiner			Due to (or as	a consequence o	of):									
¥ \$	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a	a consequence o	of):		_							
uted d ansit	ᇤ	cause. Enter Underlying Cause (Disease or injury												
exection and ital-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence o	of);									
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai	d											_	
ng ph	cian/Medical	IF FEMALE:							-		1			
th ce tendi	an/l	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □E	ctopic preg	gnancy					te of delive	,	Year
e dea	sici	1 Vac 2 X No	□Pregnant at □Unknown	time of death	5 🗆 0	Other (spec	cify)				IVIC		Duy	our
w requires that the deben signed by the should be detached	Physic	Part II. Other significant conditions contribu	ting to death hi	it not resulting in	the unde	erlying car	ISO CIVO	n in Part I		23e. Did toba	acco use conf	ribute to th	ne cause of c	feath?
requires the	l by	Respiratory Arrest	ing to doubt be	at not rootaling in	tho dilde	onying out	230 g. FO	THIT GIVE.			2 🗓 No		ably 4 🗀	
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rs after all Disagraphics and Disagraphi	Cer									, , , , , , ,				
To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1X Certifying Physicia (Check only 2 Medical Examiner:	On the basis of	examination and										i)
the I	Med	one) 29b. Signature and title of certifier	and manner sta	ited.				number			d. Date signe			
To To cor		296. Signature and title of certifier	7.1	M	\cap	7	. 1	Q Q 3	7 7	25	10 /	d/n.	- wy, r \(\alpha \)	
00		1	soap	Dath (ltom 20=1)	June 2	リリ	10	770	メン		//	1/04	00511	
KS)		30. Name and address of person who complete Marie A. Dobyns, MD					#46	50. T.:	aurei	l, Maryl	and 20	707		
Sta	te.	31. Date filed (Month, Day, Year)	T	ar's Signature		,	a TC	, ш		-, -14171				
Registr		nct 1 9 2004	100	. K	Sociel									

Please Type or Print in Black indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 34846 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Month **Physician** October 15, 2004 5:50AM Bertha Rudden /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Locetion of Death 4c. County of Death Examiner Montgomery Manor Care Potomac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) June 4,1907 5. Social Security Number 7. Age (In vrs. lest birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1□M 211 F Yrs. 220-46-5580 Washington, DC Director Usuel Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Maryland nent of Health and Mentel Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23a or 28s-f show ury or other than "naturel", or Items 2a notified all ury or other traumatic event, The Medical Examples must be notified at 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Bethesda Maryland Montgomery 10g. Citizen of Whet Country? 10f. Zip Code 10e. Street end Number 20817 United States of America 7420 Westlake Terrace #1107 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0020 Specify: Completed by 3 KWidowed 4 Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Emma Brevsky Joseph Oxenburg 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Ronald P. Rudden - Son 9900 Harrogate Road, Bethesda, Maryland 20817 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Depertment of important: If it any injury or or or one. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Adas Israel Cong. Cemetery 10/17/04 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. 1091 Rockville Pike, Rockville, MD 20852 23a. Part1. Enter the disease, or complications that caused the stath. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in deeth) /Medical a. Sepsis Examiner Due to (or es a consequence of): Physician/Medical Examiner Pneumonia ettending physician end I for use es the buriel-trensit Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Complete Heart Failure Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Chronic Renal Insufficiency Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 3Unknown Hypertension þ ete hes been signe page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Anemia 1 Vee 2 XNO 1 ☐ Yes 2 ☐ No certificete After this certific funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 XX Nursing Home 5 - Residence 6 - Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident ours effer deau.

Ni Director: Atr.

in by the fire 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 I Homicide To the Hospital of within 24 hours of To the Funeral D completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20274 October 15, 2004 12 30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Kirti Vohra

OCT

19

2004

31. Date filed (Month, Day, Year)

32. Registrar's Signeture

7710 Bradley Blvd. Bethesda, Maryland 20817

oaks

		1 - State Registrer	otato ot	,	Certificate of	of Death	a monta, , , ,	giene 2004	3484
Physicia	an	1. Decedent's Name (First, Middle					2. Date of Dea	Day Year	3. Time of Death
/Medic		James Ale 4a. Facility Name (If not institution			4h City Tour	n, or Location of D	October		2201 P
Examin	er	2717 Kingsway F	. •	Dei)		Vashingto		4c. County of Death Prince Ge	orgola
Funeral		5. Social Security Number		7. Age (In yrs. last bir	thday) If Under 1 Ye	ar If Under 24	Hrs. 8 Date of Birt	b D Binto	lace (State or Fore
Director		578-28-8503	1 ∑ M 2□F	79	Yrs. Months Da	ys Hours A	Min. (Month, Day March	v, Year) Cour	rginia
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				
Manyli f sho	ō							'	0d. Inside City Lim 1 ☐ Yes 2 ☐
death with the Maryland ms 23e or 28e-f show	Dire	Maryland Prin 10e. Street and Number	ce Georgi	e's Fo	rt Washii 101. Zip Coo			10g. Citizen of What Cour	
s 23s	Funeral	2717 Kingswa	y Road	dent Ever in U.S.	207			US	
2 ± 3	'n	11. Marital Status 1 ☐ Never Mamed 2 ☐ Marri	Armed Ford	ces?	If Yes, specify C	uban, Mexican, Pi	' (Specify Yes or No- Jerto Rican, etc.)	14. Race - Ameno Black, White,	
urs a	þ	3 ♥ Widowed 4 Divorced	If Yes, Give	tes:W.W.II	1 ☐ Yes 2 🔯 I	No Specify:		Specify: Bla	ck
72 hours	Completed	15. Decedent (Specify only highes	's Education	16a.	Decedent's Usual Oc	cupation	warking	16b. Kind of Business/Inc	dustry
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hould Me mark matic	ဥ	William R 19a. Informant's Name/Relationsh	OY	195	Mailing Address (Str.			a Johnson r, City or Town, State, Zip	0-4-1
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portification is interested within product Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other treumatic event, Ira Mode.		20a. Method of Disposition		20b. Place of	Disposition (Name of	1	Date	20c. Location - City or To	
Page ento nt: F		YDYBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sg			y, crematory or other ; 1n Memor:	la i	/10/04	Omilia - Ja	
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death certifice	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birt	ome of pregnancy th 2 Fetal death nt at time of death wn	3 ☐Ectopic pregna 5 ☐ Other (specify)			23d. Date of deliver	,
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equires that the de en signed by the a	þ	Part II. Other significant condition	ns contributing to dea	ath but not resulting in	the underlying cause	given in Part I.		bacco use contribute to the	e cause of death?
		Part II. Other significant conditio	ns contributing to dea	ath but not resulting in	the underlying cause	given in Part I.		n 24b. Were autop	e cause of death? Ably 4 DOnknow Sy findings available tion of cause of
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Examin		4a. Facility Name (If not institution, give s	44 - 1 /		r Location of Death	40	. County of Death	
Funeral		5. Social Security Number 6. Sex	_	Selisb st birthday) If Under 1 Year	If Under 24 Hrs. 8	Date of Birth	9. Birtho	lace (State or Foreign
Director		218-34-8101	M 2□F 66	Yrs. Months Days	Hours Min.	Month, Day, Year,	Coun	ryland
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with the	Director	10e. Street and Number	-1-1-1	10f. Zip Code	21659	10g. Cî	tizen of What Coun	try?
ns 236	erai		SICK ROA 12. Was Decedent Ever in U.S.	. 13. Was Decedent of H	3 7 Hispanic Origin? (Specify	Yes or No-	14. Race - Americ	an Indian,
or Her	by Funerai	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	If Yes, specify Cub.	an, Mexican, Puerto Rica Specity:	in, etc.)	Black, White, of Specify:	etc.
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s 1 and 2 should be lied within 72 hours after death with the Marylan to Health and Mental Hygiene. I them 27 Is marked other than "natural", or items 23e or 28e-f show other treumetic evant. Its Medical Evantinar must be notified at	2	19a. Informant's Name/Relationship (Ty)		19b. Mailing Address (Street	Flossiand Number or Rural Ro	ute Number, City		e 5 Code 21659
and 2 ealth m 27 I har tre			Roberts	4205 Mess		Chodeso		21859
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permil. Depart Import any inj		Janelle C.	Henry	Slowash	inaton St. (ambric	lae, MD.	21613
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Jeath certiticate I attending physicator at the k	Med	IF FEMALE:	0- 14					
attenc attenc I tor us	Physician/M	in the past 12 months?	3c. If yes, outcome of pregnand 1 Live birth 2 Fetal d 4 Pregnant at time of dea	leath 3 Ectopic pregnancy	1		23d. Date of deliver Month	y Day Year
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Division of Vital Records, P.O. Box 68760,

State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar 34849 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Paul 11:00P M Michael Riggins 10, October 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9717 Ocean Gateway Easton Talbot If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Days 1∰M 2□F Yrs Maryland Director 215-44-6057 Dec 22,1945 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits irel', or Items 23a or 28e-f show Examiner must be notified at 1 ☐ Yes XXNo Talbot Maryland Easton Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zio Code 9717 Ocean Gateway 21601 US Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Item any injury or other traumatic event, the Medical Evantment once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: ⋧ 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rubin Sleighter Riggins Virginia Hayward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Riggins Daughter 2578 Deep Grass Lane Greenwood, Delaware 19950 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dorchester Mem. Park 10/14/04 Cambridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas Funeral Home, PA
700 Locust Street Cambridge, Maryland 21. Signature of fruneral Service Licensee 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw cardiovascular disease Immediate Cause (Final arterio scherotici **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and thed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown ρ signed b Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð possible dehydration 1 Yes 2 No 3 Probably 4 Unknown Completed peeu : 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe certificate 1 ☐ Yes 2 € No 1 Yes 2 No Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1€Yes 2 No ို 2 ER/Outpatient 3□ DOA this 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 1 Natural 5 Pending investigation death. 1 Tyes 2 No 2 Accident within 24 hours after deat To the Funerel Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature at D6044282 of death (Item 23a) (Type, Print) Kopnouski, MD 4410 Becholons Pt Rd Oxxens ma 21654 State Registrar

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of	g Phys er this eral di	\vdash	1 Yes 2 Monner of Death		28a. Date	of Injury	ER/Outpaties 28b. Time o	IL 3 DOA	4 🗆 14	ursing Home 5 Res 28d. Describe	idence 6 □0 how injury occu		(y)
ion	Attending r death. ector: After by the fune	atio	2 Accident	5 Pending investigat	tion	h, Day Yeer)	Injury		ork?]Yes 2.[]No			
Division of Vital Records,	or Attend after death Director: / Jin by the f	ertification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	ed 28e. Place buildi	of Injury - At h ng, etc. (Special	ome, farm, st fy)	eet, factory, office			(Street and Nun own, State)	nber or Rura	l Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	0	29a. Certifier 1	eertifying	Physicien: To the	best of my kno	owledge, deat	h occurred at the t	ime, date a	nd place, and due to the	a causa(s) and n	nannar as si	tated
	n 24 h n 24 h ne Fur sietely	edical	(Check only 2 one)	☐ Medical Ex	saminer: On the ba	asis of examina	ation and/or in	vestigation, in my	opinion, de	ath occurred at the time	, date and place	, and due to	the cause(s)
	To the h within 24 To the f complete	Ž	29b. Signature and titl	le of certifier				29c. Licen	se number	777	29d. Date sign	ed (Month,	Dey, Year)
				NAM	nu				112	555	10	16/0	07
			30. Name and address Thomas					•	k a lnd	, Md. 21550	·	·	i
	Sta	te	31. Date filed (Month,	Day, Year)	32. R	egistr á r's Signa		8 . D.	WATHU	, 114, 21000			
	Registr	ar		OCT I	L 3) 2004	A TOOL	d Do	A STATE OF THE STA					

		•	1- State of Maryland / Department of Health and Me Certificate of Death	ental Hygier Reg. r	L UUY (34852
				2. Date of Death		3. Time of Death
	Physicia /Medic		ANDREW SNELL JR.	Month D	Day Yeer	4:54 00
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	7
			5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs.		wirester	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplac Country	e (State or Foreign
		٥	Usuel Residence of Decedent	March 7	1434	5.0
	nyland how		10a. State 10b. County 10c. City, Town or Location		10d.	. Inside City Limits
	e Ma Be-fa	cto	MD Worcester Berlin			1 Yes 2 No
	with the		10e. Street and Number 10f. Zip Code 2/8/11	10g. (Citizen of What Country	?
	eath	Funeral Director	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	U.S.A.	Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Inprocess. If Item 27 is marked other than "natural", or Items 23a or 28e-f ahow ary injury or other traumatic evant, the Modical Examitter must be rigitlised at once.	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1	lican, etc.)	Specify: R/S	CK
21215-0036	2 hou	ted	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/Indus	stry
2	thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of working life. DO NOT use retired)	_		,
	filed wi Hygien other th	S	10th Grade Owner/OPerata-		N 75. Cor	struction
and	ntal H ed ot	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (One of the Control of	,		- 1
Maryland	should nd Men marke umatic	၉	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural	Route Number, Cin		nde)
\mathbf{z}	nd 2 salth ar 27 is r trau		Christia, 50011-WIFE 12114 Supervisent	Rd Br	hi me c	21811
Ē,	is 1 and of Heal ltem 2		20a. Method of Disposition (Name of Day Disposition (Name of Disposition		Locati in - City or Town	
Ē	Pages nent of I ant: If Its ary or o			3104 B	erlin mi)
Baltimore,	permit. Page Department of Improctant: If any injury or once.	Ì	'4 □ Donation 5 □ Other (Specify) 21. Signal Thur ral Service Licensee 22. Name and Address of Facility 3 □ PRINTS (Exercise) 22. Name and Address of Facility 3 □ PRINTS (Exercise)	ennies	m1+15 741	read Home
80	80589		moule Tod 717 W. Isabella	5+-5=1	istory, md	21801
П			23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.	respiratory arrest,	Ap In	oproximate terval Between nset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		4	124NS
П	Examiner		Due to (or as a consequence of):			,
		je	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
	cuted nd ransit	Examiner	cause. Enter Underlying Cause Unsured or many that initiated events c.		37	
<u>0</u>	e exe ian a urial-t		resulting in death) Last Due to (or as a consequence of):		100 mg	
58760,	res that the death certificate be executed igned by the attending physician and be detached for use as the buriat-transit	edicai	d			
_	certiffi ding		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery	
Вох	d for u	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1		Month Da	y Year
P.O.	t the c by the tacher	hys	9 Unknown 9 Unknown			
	es tha gned be de	by P	Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the c	
ord	w requir been sl should			Yes	2 No 3 Probabl	y 4 ∐Unknown
of Vital Records,	ca co co	Completed		24a. Was an autopsy	24b. Were autopsy prior to comple	findings available etion of cause of
H H	the The			1 Yes		X No
Z:	sicier certif rector	Be	25. Was case referred to medical 26. Place of Death (27) and the common of the common			
ō	Physic Price of the peral of	r; 10	27 Jumper of Death 28a, Date of Injury 28b, Time of 28c, Injury at 28	e 5 sidence 3d. Describe how in	6 □Other (Specify) jury occurred	
<u>ö</u>	ath. r: Afte	atio	Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
Division	or Attend frer death birector: A	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	3f. Location (Street a City or Town, Sta	and Number or Rural Ro Ite)	oute Number,
	pitel ours a eral C		29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, an	nd due to the caucat	(e) and manner as state	d
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page.	Medical	(Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d at the time, date a	nd place, and due to the	e cause(s)
	To t To t	Σ	29b Signatore and title of certifier 29c. License number		Date signed (Month, Day	
.	1	4	WHO COLIND NOCH!		10-19-0	//
A			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	lish	MD 21	802
	Sta	te	31. Date filed (Montt) Day Year) 2 2004 32. Registrar's Signature		7.10 - //	
		ar	UCIT O 2004 Jerry De places			

				1 - State of Maryland / Department of Health and Me Certificate of Death	ental Hygier	2004 34853
		Physici		TOWN CLOAN CTELIADT	2. Date of Death	Day Year 10,30 PM
•		/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death And Hospia Characteristics As Parallel Hospia		4c. County of Death Anne Armole
		Funeral Director		309-09-0361 1XM 2 F 84 Yrs. Months Days Hours Min. O	B. Date of Birth (Month, Day, Yea) CT. 8, 1	9. Birthplace (State or Foreign Country) PENNSYLVANIA
		show		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
		Ba-f st	Director	MD ANNE ARUNDEL SEVERNA PARK		1 ☐ Yes 2 📉 No
Lohn.		Sa or 2				Citizen of What Country?
10		death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric		14. Race - American Indian,
~	215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hygjene. I marked other then "natural", or items 23a or 28a-f show unatic event, if a Maryland Examilian must be notified at	by	3 □ Widowed 4 □ Divorced Year or Dates: TINIX		Black, White, etc. Specify: WHITE
Stewart	215-	hin 72 an "nat	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ASSTSTANT TAROR RETATION	7	. Kind of Business/Industry
6	21	led within ygiene. her then it, If e M.			R	AILROAD
34	Maryland	s 1 and 2 should be filed within 72 hr I Health and Mental Hygiene. Item 27 is marked other then "natural other treumatic event, It's Madical	To Be	JUHN SLUAN STEWART HARRIETT	ROBERTS	
	Mai	and 2 st salth and n 27 is n		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rural F</i> 345 WRIGHTS LANE, EXTON		
	ore,	of Health of Health if item 27 is or other tre		20a. Method of Disposition 20b. Place of Disposition (Name of Computer Comp		Location - City or Town, State
	Baltimore,	: Pages tment of I tent: If it		1 Burial 2 Termation 3 Removal from State 4 Donation 5 Other (Specify) CHESAPEAKE CREMATORY 10/08/	2004 ST	EVENSVILLE, MD
í	Ba	permit. Pages Department of Importent: If i any injury or o		21. Signature of Furreral Service Licensee 22. Name and Address of Facility ADAMS OF ANNAPOLIS FU 814 BESTGATE RD., ANN	VAPOLIS.	MEMORIAL CARE, MD 21401
	I,	markes		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or r shock, or heart failure. List only one cause on each line.	espiratory arrest,	Approximate Interval Between Onset and Death
		Prrysician /Medical		Immediate Cause (Final disease or condition resulting in death) Live Encephaltts Due to (or as a consequence of):		
		Examiner		Secuentially list conditions b Septice mia		
,		uted J unsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury Atrial Elby Matron		
ç	Ö,	be executed sician and burial-transit				
1	8760,	physici the bu	dlcal	d		
C	P.O. Box 6	ne death certif the attending thed for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ Unknown		23d. Date of delivery Month Day Year
7	Division of Vital Records, P.	w requires that the back that	by	Part is other significant conditions contributing to death out not resulting in the underlying cause given in Part i.	23e. Did tobacco	o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
	ဝင္	law re nas bee	Completed		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
-	e E	icien: The L certificate ha ector, page			performed?	death?
	<u> </u>	ysicien; is certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No		6 ☐Other (Specify)
1	<u>_</u>	ding Ph h. After thi funeral			d. Describe how in	
(<u> </u>	vttendii death. ctor: A y the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	Location (Street	and Alimberta Devil Devil Alimberta
č	<u>≥</u>	s after o	Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	and Number or Rural Route Number, ate)
		To the Hospitel or Att within 24 hours after d To the Funerel Direct completely filled in by	edical (29a. Certifier (Check only one) 1 **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and compared to the time, date and time	d due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)
		To the To the Comp	≥	29b. Signature and title of certifier 29c. License number 29c. License number 29c. License number	29d. D	Date signed (Month, Day, Year)
				30 Name and address of person who completed cause of death //tem 23a) (Time Drink)	Uct	oper 6, 2001
				Jeonge C. Wulk II D. 30. Name and address of person who completed cause of death (Item 23a) (Type. Print) Service E. Wicks II D. 301 Hospital Drive, G. 31. Date filed (Month, Day, Year) 32. Registrar's Signature	len Bu	mie, MJ, 21043
	**	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature		

			1 For State	State of Maryland / D	epartment o		nd Mental Hyg	jiene	
	Q	A	1. Decedent's Name (First, Middle,	Last)	Jorimouto	OI Deatil	2. Date of Dea	411	3. 1m. 8.5.th
	Physici /Medic		Roland	Sliker			Month (O	Day Year 18 2004	2 P M
	Examir		4a. Facility Name (If not institution,	give street and number)	4b. City, To	wn, or Location of	Death	4c. County of Deat	1
			5810 Green Land			Marlbor		Prince G	eorge's
г	Funeral Director		5. Social Security Number 146–14–0955	i. Sex 1 M 2 □ F 7. Age (In yrs. last birth 93 Y			Hrs. 8. Date of Birth (Month, Day Sept 21	, 1911 Penr	nplace (State or Foreign intry) ISV1vania
	ਰੂ		Usual Residence of Decedent					, ====	
	anylar show	5	10a. State 10b. County	10c. City, Town					10d. Inside City Limits 1 Yes 2 □ No
	the M	Director	Maryland Prince 10e. Street and Number	George's Upper	Marlboro	ndo		0g. Citizen of What Co	1
	with Sa or		5810 Green Land	ling Pood	101. Zip Cc	20772			antry ?
	ms 2;	era	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Deceder		n? (Specify Yes or No- Puerto Rican, etc.)	U.S.A.	ican Indian,
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "neturel", or Itams 23e or 28e-f show or other treumetic event, It a Medical Examinar must be nailling at	Completed by Funeral	1 ☐ Never Married 2 ☐X Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1966	If Yes, specify	_	Puerto Rican, etc.)	Black, White	n, etc. hite
21215-0036	72 hor	ted	15. Decedent's (Specify only highest	Education 16a. [Decedent's Usual (Occupation done during most o	d westing	16b. Kind of Business/l	ndustry
21	ithin 7	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	retired)	or working		
	led w tygier her th		17, Father's Name (First, Middle, La		lonel_			U.S. Air	Force
Maryland	d be fi	o Be	George Sliker	ist)			s Name <i>(First, Middl</i> e, <i>l</i> 1 Ana Myers		
JZ.	shoul nd Me mark	은	19a. Informant's Name/Relationship	o (Type, Print) 19b.	Mailing Address (S			, City or Town, State, Z	ip Code)
	and 2 ealth a n 27 is		Helen Sliker - W					Marlboro,	
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre once.		20a. Method of Disposition	20b. Place of I	Disposition (Name crematory or othe	of !		20c. Location - City or T	
Ĕ	Pages ment of ent: If it ury or o		`4 ☐ Donation 5 ☐ Other (Spe		Episcopal	Cemetery 1	10/21/2004	Upper Marll	oro, MD
3alt	permit. Departn Importe any inju		21. Signature of Fundral Service Lie		22. Name and A	Address of Facility	Gasch's Fu	neral Home	, P.A.
	OD F @ O		I Alleach	Mallo 1101373				ttsville, l	
E			snock, or near failure. List or			of dying, such as ca	irdiac or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a bladder car					2 months
	Examiner			Due to (or as a consequence of	/5				
		Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	b):				
	cuted nd ransit	Examiner	that initiated events	c					
, 00	cate be executed physician and the burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	¢.	,			
8760,	cate b	dlcal		d					
9 x	certifi Iding I	Φ	IF FEMALE:	23c. If yes, outcome of pregnancy	-		2001	204 Day 4445	
Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death	3 ☐ Ectopic pregr 5 ☐ Other (special			23d. Date of delin	ery Day Year
P.0	at the de by the tached	hys	9 🗆 Unknown	9□ Unknown					
	res tha igned be det		Part II. Other significant condition	s contributing to death but not resulting in t	ne underlying caus	se given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ord	w requir been si should	ted					1 🗆 Ye	s 2 No 3 Pro	bably 4 Unknown
Records,	elawi hasbu je 2 sh	Completed by					24a. Was ar autops	y prior to co	opsy findings available ompletion of cause of
E F							perform	ned? death?	2□ No
Vital	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:		Other	Death (Check only one		-
of	g Physter this	\vdash	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date of Injury (Month, Day Year) 28b. Tir		4 □ Nursi	ng Home 5 X Reside 28d. Describe ho	nce 6 Other (Speci w injury occurred	fy)
ion	nding l th. r: Atter e funer	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		ury M	Work? 1 ☐ Yes 2 ☐ No		,,	
Division	r Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could no determine		, street, factory, of	ffice	28f. Location (Str. City or Town	reet and Number or Rur	al Route Number,
Ö	itel or irs aft rel Di	Cer							
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: Attercompletely filled in by the funer	Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of my knowledge, aminer: On the basis of examination and/ and manner stated.	leath occurred at to investigation, in	he time, date and p my opinion, death	place, and due to the ca occurred at the time, da	luse(s) and manner as s ite and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	100		icense number		d. Date signed (Month,	9
	111	- 11	M. Cemi	nerMD	DC	05917	5	10-18	-04
R	12) lVa		Kathleen Ker	no completed cause of death (Item 23a) (T NMEN, 900 Best a	ote Rel	#300	Annapolis,	10-18 MD 214	0/
:3	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 0 20	2. Registrar's Signature	ante				

			For State Registrar	State of M	aryland /		ment of H		Mental H	ygiene 001	34855
			Decedent's Name (First, Middle, I	Last)					2. Date of D		3. Time of Death
	Physici		Nicholas	T. Sis	strun				OCTOB	ER Day 5 20	12:30 A M
	/Medic Examin		4a. Facility Name (If not institution, g			41	. City, Town, or	Location of De		4c. County of E	
			Doctor's Communi	ty Hospital	L		Lanham			Prince	George's
	Funeral			. Sex 7. Ag	e (In yrs. last		Under 1 Year onths Days	If Under 24 H			Birthplace (State or Foreign Country)
	Director		166-07-5966	1 X M 2□F	94	Yrs.	Unitis Days	Hours Wil			ennsylvania
	Pu ≱		Usual Residence of Decedent 10a. State 10b. County		10c City To	own or Location	on.				
	shor	7		_	Toc. Oity, 10	JWII OI LOCALII	OII				10d. Inside City Limits 1
	he N	ect	Maryland Prince	George's	Chev					1	Λ
	with	Ď	1715 62nd Av				10f. Zip Code			10g. Citizen of Wha	t Country?
	eath	erai	17.13 OZIIQ AV	12. Was Decedent	Ever in II S	12 14/25	20785	anania Origin?	(Consider Van as h	U.S.A.	American Indian.
	ter d	ü	1 Never Married 2 Married	Armed Forces?	No.	í	is, specify Cuba	n, Mexican, Pue	(Specify Yes or N erto Rican, etc.)		Vhite, etc.
99	urs af	by	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	If Yes, Give Year or Dates:	1944	10	Yes 2█ No	Specify:		Specify:	African-
ŏ	filed within 72 hours after death with the Maryland Hyglene. ther then "neturel", or flems 23e or 28e-f show ther the Medical Examinar must be notified at	Completed by Funeral Director	15. Decedent's	Education	1945	Sa. Decedent	's Usual Occupa	ation		16b. Kind of Busine	nerican ess/Industry
2	hin 7	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO	l of work done d NOT use retired	luring most of w)	rofking		
2	ad wil	Con	8		C	ivil E	ngineer	/Contra	ctor	Federal (Government
2	al Hy al Hy doth	Be (17. Father's Name (First, Middle, La	st)				18. Mother's N	ame (First, Middi	le, Maiden Sumame)	
Maryland 21215-0036	Ment Ment arked	T _O	William Sist	run				F1o	ra Jacks	son	
a	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23e or 28e-f show any fujury or other treumetic event, the Medical Examiner must be notified at once.	6 1	19a. Informant's Name/Relationship		1					ber, City or Town, Sta	
≥ .	and ealth m 27		Yvette Ellard ·	- Daughter				ue, Che		Maryland 20	
ore	jes 1 lof H If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	☐Removal from State		of Dispositio tery, cremato		9) 10/	Date	20c. Location - City	or Town, State
Baltimore,	Pag ment ent: lury c		`4 Donation 5 □ Other (Spe	cify)	Maryl	and Vet	erans Ce	metery "	22/2004		am, Maryland
<u>3</u>	eparti eparti nporti ny Inj		21. Signature J Funeral Syrving Lit	7		22. Na	ime and Addres	s of Facility (asch's .	Funeral Hor	
_	90 E 8 9	11 11	-olelle	1102/	<u></u>					yattsville	, MD 20781
н			23a. Parti. Enter the disease, or co shock, or heart failure. List on	implications that caused by one cause on each li	the death. D	o not enter th	e mode of dying				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Mulet	ustre	De C	16	Con	Caro	26	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence	e of):		00	Carc	~	
H	Lxumici	_	Sequentially list conditions, if any, leading to immediate	b. 150	ele	100	225/	ta	elle	re	
	pe #s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequenc	e of):					
	and I-tran	xan	that initiated events resulting in death) Last	c	a consequenc	e of):					
760,	tte be executed lysician and ne burial-transit	icai E		550 (0) 20	a consequence	lo 017.					
687	phys the	dic		d							
	eath certific attending p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnancy					22d Data of	dolivon
Вох	atter I for u	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal dea		opic pregnancy ner (specify)			23d. Date of Month	Day Year
o.	the d y the iched	ıysi	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown							
О.	w requires that the de been signed by the should be detached	y Pr	Part II. Other significant conditions	contributing to death b	ut not resulting	in the under	lying cause give	n in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
g	pures	d by	Chonic	· Blad	eles	out	tlet	Yosto	ectant	Yes 2□No 3□	Probably 4 Dunknown
Records,	w req beer shou	iete	CAm Co	- 0= - A-	by				24a. Wa	s an 24h Were	autopsy findings available
Re	he lav e has	Completed	Dia sil di	14 -	7-6-	~ \			auto	opsy prior death	to completion of cause of
g	ilcien: Th certificate rector, pag		25. Was case referred to medical	174/20	1088	Jou	7	00 Di 4 D	1 ☐ Yes		′es 2□No
>	ysicien: The is certificate hadirector, page	To Be	examiner? 1 ☐ Yes 2 🏋 No	Hospital:	ent 2 FR/	Outpatient 3	Othe			one sidence 6 □Other (S	and the same of th
0	g Phy er this		27. Manner of Death	28a. Date of Inju (Month, Da		. Time of	28c. Injury Work			how injury occurred	респу)
0	nding F ath. r: After e funera	atio	1 □Natural 5 □ Pending 2 □ Accident investigat		y rear)	Injury I		? ′es 2 ☐ No			
Division of Vital	r Attencer death rector: by the	ifica	3 Suicide 6 Could not determine	be 28e. Place of Inju-	ury - At home,	farm, street,	factory, office			(Street and Number or	Rural Route Number,
	s after s afte	Certification:		bulluling, etc	c. (Specify)				City of Te	own, State)	
	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within £4 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying I	Physician: To the best caminer: On the basis of	of my knowled	ge, death occ	curred at the tim	e, date and place	ce, and due to the	e cause(s) and manner	as stated.
	the F the F the F	Medicai	one)	and manner sta	ated.				oned at the time		
	Vaith To Con	2	29b. Signature and title of certifier				29c. License	number		29d. Date signed (Mo	
	0 111		0	How)		MD	D31528		10/16/	64
-	4/109		30. Name and address of person wh					1	1	0705	
	١		Margaret Akpan, 31. Date filed (Month, Day, Year)				, Cheve	r⊥y, Ma	ryland 2	20/85	
	Sta Registr		OCT 2 0 20	04 Kenne	ar's Signature	Goods					

DHMH 17 Rev 1/2001

Nicholas T. SISTRUN

State of Maryland / Department of Health and Mental Hygieney 1 - For State Registrar 34856 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** BEATRICE L. STRICKLER October 0 17, 2004 12:17 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex Birthplace (State or Foreign Country) Months 1 ☐ M 2 🛚 F Days Hours Min. Yrs. 69 Director 217-32-0844 1935 16, Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits iral', or itams 23a or 28a-f show Exeminer must be notified at 1 K Yes 2 □ No Directo Prince George's Maryland Berwyn Heights 10e. Street and Number 10g. Citizen of What Country? 8719 63rd Avenue 20740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ŽĎ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status o filad within 72 hours after de I Hygiene. Other than "natural", or Itam 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filad wit Department of Haalth and Mental Hygiene Important: If item 27 is marked other the uportant: or other treatmatic event, ILE ORIGE. 12 Bookkeeper Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Albert Dodson Bertha Virginia Bailey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Arrowood - Daughter 9309 Meredith Ave., Laurel, Maryland 20723 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 10/20/2004 Brentwood, Maryland 22. Name and Address of Facility Gasch's Funeral Home, P.A. 21. Signature of Funeral Service Licensee 4739 Baltimore Ave., Hyattsville, MD 20781 May 1 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Subendo (arti) disease or condition resulting in death) Trocius /Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-transit The law requires that the death certificata be axecuted nd inferr inforce attending physician and Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Tetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔯 No 4□Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown Š Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ pe 1 Yes 2 No 3 Probably 4 XUnknown Completed 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? Insu. certificate has make tes 2□ No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 🔀 No 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number oct 10,2004 22/1/ 0 30. Name and address of person who impleted cause of death (Item 23a) (Type, Print) Thomas Y. Ko, MD 8100 Good Luck Road, Lanham, Maryland 20706 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 34857 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year PETER E. SHAPIRO OCTOBER /Medical 16, 2004 1:20 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUBURBAN HOSPITAL **BETHESDA** MONTGOMERY 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign
Country) 1XM 2□F Director 077-82-6655 Yrs 71 17 JAN. 1933 RUSSÍA Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ust be notified at Directo 1 X Yes 2 ☐ No MARYLAND MONTGOMERY ROCKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 23a 254 CONGRESSIONAL LANE #T-3 20852 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: or Itams Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic evant, the Medical Examinery 14. Race - American Indian. Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 β 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: WHITE natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 d 2 should be filed w h and Mental Hygier 7 is markad othar th SCULPTOR ART 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 EFIAM SHAPIRO NINA HOLLANDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ages 1 and 2 sl nt of Health an : If itam 27 is r ANJELIKA PLAVAN/WIFE 254 CONGRESSIONAL LANE #T-3, ROCKVILLE, MD 20852 othar t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages I Department of H Important: If ita 1 X Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESED SHEL EMMES 10/19/2004 WASHINGTON, DC 21. Signature of Funeral Service Licenses Name and Address of Facility NZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 70 ROCKVILLE PIKE, ROCKVILLE, MD 20852 any ir Milling 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each life. Immediate Cause (Final disease or condition resulting in death) iysician COMMUNITY ACQUIRED PNEUMONIA /Medical Due to (or as a consequence of): **Examiner** ANASARCA Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 □ Yes 2 □ No 3 Ectopic pregnancy ò 4☐Pregnant at time of death Month Day 5 ☐ Other (specify) o. 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ BLADDER CARCINOMA Be Completed 1 ☐ Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No page 2 s 24a Wasan autopsy performed? Vital 1 ☐ Yes 2X No Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 ☐ Yes 2 🔀 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attanding 1 X Natural 5 Pending 24 hours after death.

Funaral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To tha 29b. Signature and title of certified 0 29c. License number 29d. Date signed (Month, Day, Year) odline D0061596 OCTOBER 17, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOANNA WEI-CHIN KU, M.D., 1201 SEVEN LOCKS RD. SUITE 200, ROCKVILLE, MD 20854 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 19 2004 200 Kil Registrar

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Modical Examinor To your or graph of the state of the st			Physician	()	Immediate Cause (Final disease or condition ISCHEMIC CARDIOMYOPATHY				
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 30b. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALPANA GOSWAMI, M.D., 11119 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 State 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALPANA GOSWAMI, M.D., 11119 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852		ta	an: T tiflicate or, pa		25. Was case referred to medical	GC Place of Dooth		2. No 1 ☐ Yes	2 No
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	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
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36	after dea or items mmer m	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 22 No	ispanic Origin? (Specif n, Mexican, Puerto Ric Specify:		14. Race - Arr Bleck, Wh Specify:	
Maryland 21215-0036	72 hours natural',		15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	16b.	Kind of Busines	
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nd	ges 1 and 2 should be filed it of Health and Menial Hygie if Item 27 is marked other or other traumatic event.	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name (F			
χ	2 should be f and Mental I is marked of aumatic eve	2	George Washing					e Jacks		
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	1 and tealth om 27 ther t		Thelma Short	(wife	The second secon	• Box 24		rsville		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other trai		20a. Method of Disposition 1 ♣ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, cree	osition (Name of matory or other place Creek Ce			ocation - City o	town, State
Bal	Depar Impor any ir		21. Signature of Funeral Service I I In	MO(0510 G	18 West	neral Hor Cross St	_Galena	tephen	L. Schaech
68760,	Physician /Medical Examiner and private private in the private reason of the private rea	ai Examiner	23a. Part1. Enter the disease, or composition, or heart failure. List only of the composition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that infitted events resulting in death) Last	b. Due to (or as a	a consequence of):					Interval Between Onset and Death
Box 687	- m =	ian/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d. - 23c. If yes, outcome of 1 □ Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of de	
P.O. I	that the de	Physician/M	1 Yes 2 No 9 Unknown	4□ Pregnant at t 9□ Unknown	time of death 5	Other (specify)			Month	Day Year
Records, I	9 5 G	by	Part II. Other significant conditions co		t not resulting in the u	nderlying cause give	n in Part I.		use contribute t	o the cause of death?
ပ္ပ	aw requir s been si 2 should l	Completed	Those smo	<i>ICES</i>				24a. Was an	24b. Were a	utopsy findings available
Ä	The I	E	V					autopsy performed?	prior to death?	completion of cause of
Vital	10	O	25. Was case referred to medical				26. Place of Death (C	1 ☐ Yes 2 ☐ No) ILIYES	2 2 N o
of V	Physician: this certificatal director, I	To B	examiner? 1 Yes 2 No	lospital: 1 🗌 Inpatien	nt 2 ER/Outpatier	t 3 DOA Othe			6 ☐Other (Spe	city)
ion o	ath. or: After the		27. Manny of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work' M 1 \(\text{Y}		Describe how inju		
Division	tal or Att	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injurbuilding, etc.	ry - At home, farm, str (Specify)	eet, factory, office	28f.	Location (Street ar City or Town, State	nd Number or Ri e)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one) Certifying Phy	sician: To the best of ner: On the basis of and manner state	examination and/or in	occurred at the time restigation, in my opi	e, date and place, and inion, death occurred a	due to the cause(s t the time, date and) and manner as d place, and due	stated. to the cause(s)
	With To t	Σ	29b. Signature and title of certifier			29c. License	60301	29d. Da	ite signed (Mont	h, Day, Year)
			361 /-	imer, MD	ath (Item 23a) (Type,	Print)	Chester	+ OTT 25	D 010	20
	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar	's Signature		CHESTEL	COWII, M	D• ₹10	20
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		•	For State Registrar	Stat	e of M	laryland	l / Depa <i>Cer</i>	rtment of H tificate of L	ealth a D <i>eath</i>	and M	lental	Hygid Reg	ene 0	04	3	4860
			Decedent's Name (First, Midd	le, Last)							2. Date of		Day	Year	3.	Time of Death
	Physicia /Medic		James A	ustin		SA	NDERS						18. 2		9	40 A M
	Examin	_	4a. Facility Name (If not institution	n, give street ar	nd number)		4b. City, Town, or	Location of	of Death			4c. Count	y of Death	1	
			Dennett Road						0akla						cret	
	Funeral		5. Social Security Number	6. Sex 1⊠ M 2		ge (In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of	n, Day, 1	Year)			State or Foreign
	Director		219-14-5063 Usuel Residence of Decedent			94	113.				Oct.	6,	1910	We	st	<u>Virginia</u>
	and		10a. State 10b. County	<i>i</i>		10c. City,	Town or Lo	cation							10d. In	side City Limits
	Mary	ò	MD (arrett				0 a k1 a	n.d					1 ☐ Yes 2 🔀		☐Yes 2XNo
	28a	rec	10e. Street and Number	allect	_			10f. Zip Code	ши			10	g. Citizen of	en of What Country?		
	3a o		2687 Fingerboa	rd Road					21550)				USA		
	death	Funeral Director	11. Marital Status	12. Was		t Ever in U.S	i. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Ori	igin? (Sp	ecify Yes o	r No-	- 14. Race - American Indian,			dian,
21215-0036	perriit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinatic rotal be inclined at ance.	by Fu	1 Never Married 2 Ma 3 ⊠ Widowed 4 Divorce	rried 1 🗆	Yes 2 es, Give r or Dates] No		Yes 2 No	Specify:		riioan, oic	•,	Black, White, etc. Specify: White			e
ŏ	2 hou	ted	15. Decede	nt's Education	n4n d)		16a. Deced	lent's Usual Occupa	ation	t of work	ina	1	6b. Kind of 8	Business/I	ndustry	
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21	d with	E C	6th					Mechan						o Rer	air	
	al Hy I oth	Be (17. Father's Name (First, Middle	, Last)					18. Mothe	er's Name	(First, M	iddle, M	aiden Suma	me)		
yla	Ment Ment arkec	၉	Austin H	Pearl	S	anders			Lulu		irgi			hroni		Grimes_
Maryland	2 sho and is m		19a. Informant's Name/Relation				19b. Mailin	g Address (Street a	and Numbe	er or Rura	al Route N	umber,	City or Town	, State, Z	ip Code)
	and ealth m 27		Nancy Shreve/c	l a ughter		20b Bla		Smouse R	oad,						Tourn S	itata
ore	t of H f of H if ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 □Removal	from State	e ce	metery, cren	natory`or other plac		Date 20c. Location - City or Town, State 0/21/04 Oakland, Maryland						
Ë	Pa tmen tent: jury		`4 ☐ Donation 5 ☐ Other (-		0ak		Cemetery	-	10/21	./04	_	0 a k1a:	nd, M	lary	1and
Baltimore,	Departing Department Important In any in gase.		21. Signature of Funeral Service	Licensee	TILL			Name and Address S. Seco	4.5	Ste			era1 1			
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or mplications	that cause	ed the death.								Steronovico (Inter	roximate val Between
	Physician		Immediate Cause (Final disease or condition											Onset and Death		
4	/Medical		resulting in death)	aD	ue to (or a	s a conseque	ence of):	cardio)vas(culta	r a	808	180	2 mon		
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	cate be executed physician and the burial-transit	dicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	/		anna at\.									
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9	w requires that the death certific been signed by the attending F should be detached for use as	/Me	IF FEMALE:	23c If ve	s outcom	e of pregnan	ncv		1,00				234 D	ate of deli	V05/	**
Вох	death certifi e attending id for use aş	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 [Live birth	2 ☐ Fetal of dea	death 3	Ectopic pregnancy Other (specify)						lonth	Day	Year
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	equires that the sen signed by th	P.	Part II. Other significant condit	ions contributin	g to death	but not resul	lting in the u	nderlying cause give	en in Part I		23e.	Did toba	cco use cor	ntribute to	the cau	use of death?
Vital Records,	uires sign ld be	d b	History of	cerebr	ovas	scula	r dis	sease				1 🗌 Yes	≱ □No	3 🗆 Pro	bably	4 Unknown
Š	w req beer shou	Completed									24a.	Was an	24b	Were aut	topsy fi	ndings available
Re	The law	Ę									ŀ	autopsy periorm	ed?	death?		on of cause of
a	ilcien: Th certificate rector, pag		25. Was case referred to medic	al .					26 Place	of Deat	(Check	es 2		1 🗆 Yes	201	NO
Ξ		To Be	examiner?	Hospital	1 🗆 Inna	tient 2 🗆 E	B/Outpatier	t 3 DOA Othe				2	, ice 6 □Ot	her (Spec	ifv)	
of			27. Manner of Death	28a.	Date of In (Month, D	-	28b. Time of	and the same of th		_			v injury occu		,	
on		ţ	1 Accident 5 ☐ Pend 2 ☐ Accident inves	ing tigation	(Month, L	ay rear)	Injury	M 1 🗆	Yes 2	No						
Division	Attendi r death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could	not be mined 28e.	Place of I	njury - At hor etc. (Specify)	ne, farm, str	eet, factory, office			28f. Locat	ion (Stre	et and Num	ber or Ru	ral Rou	te Number,
Ö	al or s afte of in	ert	4 Homicide		building,	etc. (Specify)	,						0(0)			
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification;	29a. Certifier 1 A Certify (Check only one) 2 Medica	I Examiner: Or	To the bes	of examinati	vledge, deatl on and/or in	occurred at the tin vestigation, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to	the cau	use(s) and m	anner as , and due	stated. to the c	cause(s)
	To th within Fo th compl	Me	29b. Signature and title of centif	ier //)			29c. License				29	d. Date sign	-		Year)
) Janalle	KITE	hti	74		D30	035				10-1	8-20	04	
	0		30. Name and address of perso	n who complete	d cause of	death (Item	23a) (Type,	Print)								
	V		Donald R.	Richt	er,	M.D.	1533	Memori	al I	riv	e Oa	k1a	nd,M	D 21	550)
		ate	31. Date filed (Month, Day, Yea		32. Regis	strar's Signati		NO.								
	Regist	rar	31. Date filed (Month, Day, Year) OCT 2 0 2004 32. Registrar's Signature													

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Registre Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 6:50 P October 17, 2004 Dorothy O. Somner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Mt. Airy

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Kline Hospice House Frederick 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 □ M 2 🗓 F 9,1914 Director 562-03-2190 90 January California Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examinating Intuit be included at 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 No Maryland Frederick Frederick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5860 Genesis Lane 21703 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married 1 □ Yes 2 No Baltimore, Maryland 21215-0036 Specify: If Yes, Give Year or Dates: Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Iven Grizzle Agnes Cumming ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21793 9839 Gordon Court, Walkersvie,
20b. Place of Disposition (Name of cemetery, crematory or other place) Lura Abbott / Daughter 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Frederick Crematory Oct. 19, 2004Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityStauffer Funeral Home 21. Signature of Funeral Service Licensee 1621 Opossumtown Fike, Frederick MD 21702 23a. Part/ Enter the disease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or requiratory arrest, shock, or board failure. List say one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant cogditions contributing to death but not resulting in the underlying cause given in Part I. by page 2 should be 3 Probably 4 Unknown 1 ☐ Yes 2 **N**o Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed' 2 🗆 No 1 ☐ Yes 1 TYes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No Certification: To 2 ER/Outpatient 3 DOA 6 Scher (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death or Attending After Injury 1 ANatural 5 Pending 2 🗌 No death. 2 Accident investigation Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funeral (To the Hospital 1 Ccrtifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of october 18,2004 er)In U completed cause of death (Item 23a) (Type, Print) Signaturè 32. Registrar's 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

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			For State Registrar	State of M	aryland		artment rtificate					giene	2001.	34862
	hysicia /Medic		1. Decedent's Name (First, Middle, La Emery Julius Swi								2. Date of De Month October	Da		3. Time of Death 5:09 A ^M
	xamin		4a. Facility Name (If not institution, given Northampton Management)			enter			Location o	of Death		4c.	County of Dea	
	neral		5. Social Security Number 6. S			ast birthday) Yrs.	If Under Months		If Under :	24 Hrs. Min.	8. Date of Birt (Month, Da July 1	th V Year)		thplace (State or Foreign ountry) th Carolina
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Maryla	lied at	tor	Maryland Frederi	ck		rederi								1 ☐ Yes 2 ☑ No
with the	De not	Funeral Director	10e. Street and Number 7060 Basswood Roa	ad			10f. Zip		703			-	izen of What Co	
r death	SE DINE	unera	11. Marital Status	12. Was Decedent Armed Forces?			Was Decede f Yes, spec	ent of Hi	spanic Orig n, Mexican	gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Ame Black, Whi	
ours afte	Eranic	þ	1 Never Married 28 Married 3 Widowed 4 Divorced	1 ⊠Yes 2 ☐ If Yes, Give Year or Dates:	1939 <u>-</u>	45	1 ☐ Yes 2	No No	Specify:				Specify: W]	nite
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should be filed within 72 hours after death with the Maryland Mantal Hygiene.	item 27 ia markad other man 'natura', of tems 23e of 26e-1 snow other traumatic evant, 11s Medical Examinar must be notified at	e Com	8 17. Father's Name (First, Middle, Last		3+7	Sheet	Meta	1 Me			(First, Middle,		nufactui Sumame)	ring
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and 2 sho	r traum		19a. Informant's Name/Relationship (John Palanci / So										or Town, State, . vn , MD 2	
ges 1 and 2 tof Health	or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		ace of Dispo ametery, crem	sition (Nam natory or ot	e of her place	e)	Oct.	23,	20c. La	ocation - City or	Town, State
permit. Pages 1 Department of H	injury injury		* 4 □ Donation 5 □ Other (Special 21. Signature of Juneral Service Lice		Rest	haven				20			erick, kkot Co	Maryland
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DIVISION OF VITAL RECOLUS, F.C. BOX 90 To the Hospital or Attending Physician: The law requires that the death certification of the fours after death.	Atter this certilicate has been signed by the attending pr funeral director, page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3□]Ectopic pre] Other (spe						23d. Date of de Month	ivery Day Year
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Vital	s certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 70	Hospital: 1 ☐ Inpati	ent 2 🗆 l	ER/Outpatien	it 3□ DO	A Othe		/	n <i>(Check only o</i> me 5 ☐ Resid		6 ☐Other (Spe	c/fy)
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To the Hospital or Attending within 24 hours after death.	to the Funeral Director: completely filled in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At ho tc. (Specify	me, farm, str					28f. Location (5 City or Tow			ural Route Number,
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Tot	com	¥	29b. Signature and title of conflier	u_		Mi		License	number 264	99	:		te signed (Mont	
2	1		30. Name and address of person who			23a) (Type,		/i+	Airu	МП	21771	*		
	Sta		Ronald E. Miller 31. Date filed (Month, Day, Year)	32. Registr	rar's Signat	ure	4	-						
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	Physicia /Medic Examin	al	Decedent's Name (First, Middle, Li John R. 4a. Facility Name (If not institution, gi	Stottlemye:	r		4b. City,	Town, or	Location o	of Death	2. Date of Dec Month Octobe	r 17	Yea 2004 County of De	8:2	e of Death
	Funeral Director	CI			e (In yrs. last	birthday) Yrs.	Cas If Under Months	Scade 1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Birt May 15	h	shing 9.8 Ma		te or Foreign
Dailinore, maryland 21213-0030	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 ehow any injury or other traumatic event, I a Medical Ever item to a collised at once.	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10c. Street and Number 14562 Pennervill 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last Emory Fleet 19a. Informant's Name/Relationship Mary Barbara Sto 20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spector) 21. Separative of Funeral Services the	Le Road 12. Was Decedent Armed Forces? 1	er ife 20b. Place cerminal c	13. 13. 14. 16a. Decedified. If the life. 1456. 16a of Disposerery, cree ericl	lof. Zip 21 Was Deceder if Yes, spec if Yes, spec if Yes, spec ing Address 2 Pen issition (Nam natory or o x Crei 2. Name an	719 719 Jent of History Cubard Cocupants do no de de retired, al En (Street a nerv: me of ther place mator de Address	Specify: Ittion uring most 18. Mothe Mary und Numbe ille ry s of Facility	er Road 0/19	(First, Middle, ae Ke1	Macl Maiden S baug ar, City or ide, 1 20c. Loc	Black, Wi Specify: V d of Busines hine (Sumame) h Town, State MD 217 ation - City (erick,	Country? merican Indianite, etc. White is/Industry Company 719 or Town, State MD ne, PA	7
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	To the Hospital or Attention within 24 hours after deall To the Funeral Director: completely filled in by the	Medical ((Check only 2 ☐ Medical Excore) 29b. Signature and title of certifier	Physicien: To the best eminer: On the basis of and manner st	of examination ated.	n and/or in	vestigation 29d		oinion, deal	th occurre	ed at the time,	date and p	signed (Mo	nth, Day, Yea	v)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

				Certi	ficate of	Death		Reg. No.	14	J40	104
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р 7	offied offied offier offier went, it	17. Fathar's Nama (First, Middle, Last)			BIIICI	18. Mother's Nan	ne (First. Middle		Bakery		
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	tal or Attending P rs efter death. al Director: After ti led in by the funere Certification:	3 Suicide 6 Could not be 4 Homicide determined	28a. Place of Injury - At hom building, atc. (Specify)	ne, farm, streat,	factory, office		28f. Location (S City or Tow	Street and Numb m, State)	er or Rural F	Route Numi	ber,
	To the Hospital or Attending Physician: The lev within 24 hours after deeth. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Cartifier (Check only one) Certifying Physical Examiner	ian: To the best of my knowl : On tha basis of examinationage mannar stated.	edge, deeth occ on and/or invasti	curred at the timigation, in my or	na, date and place, pinion, death occur	and due to the cred at the time, c	cause(s) and ma date and place, a	nner as stat and due to th	ed. ne cause(s)	;)
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			2/1		Dy	13091		10-2	2-04		
	5	30. Name and address of person who comp				7	3m 01=5				
		Saeed A. Zaidi, MD 31. Data filed (Month, Day, Year)	801 To11 Hou			,	MD 2170	<u> </u>			
	State Registrar	OCT 2 0	32. Registrar's Signatu 2004	The /	9 14	outs!					

State of Maryland / Department of Health and Mental Hygiene 00 L 34865 1- Stata Ragistrar Amend #26, per MD, FCHD, SL, 10/20 Per tificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** ELEANOR SMITH October 0 14, 8:10 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lee Hill Circle 5008 Monrovia <u>Frederick</u> If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖾 F Yrs. Director 516-28-5241 June 3, 1927 Montana Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "natural", or Items 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Frederick Monrovia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5008 Lee Hill Circle 21770 Funeral <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Item any njury or other treumatic event 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ Specify: White 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ John Gordon McLeod Ruth Betters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy S. Wright / Daughter 5008 Lee Hill Circle Monrovia, Maryland 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State October 20, 1.4 □ Donation 5 □ Other (Specify) Prospect Cemetery 2004 Mt. Airy, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature Emperar Service L 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, shock, or heart failure. L , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Melogenous /Medical Due to (or as a consequence of) Examiner Polycy Them Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 Yes 2 No 1 ☐ Yes 2 ☐ No the Hospitel or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check only one examiner' 1 Yes 2 Hospital: 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) this **ER/Outpatient** 3 DOA 28a. Date of Injury (Month, Day Year) Certification: Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. 2 Accident investigation 1 Yes 2 No Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide 24 hours a pellit Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ca completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltinoie MA X Litherd Ave. Ross 1025 treitt MO 720 2120 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2 0

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	Funeral Director		5. Social Security Num 249-62-33	19 6. S	ex 7. ₽	Age (In yrs. Ia 64	as <i>t birthday)</i> Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. 8 Min. A	Date of Bird Month Da PTI1	th (1925 gar)	1940 9. Birth	place (State or Fore	∍ign
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	er de	nue	11. Marital Status		12. Was Deceder Armed Forces	s?	3. 13.	Was Deced f Yes, spec	ent of H ify Cuba	ispanic Origi n, Mexican,	in? (Speci Puerto Ric	ly Yes or No can, etc.)	-	 Race - Ameri Black, White, 		
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Baltimore,	90=5	1 1	20a. Method of Dispos 1 Burial 2 C	sition Cremation 3	Removal from Stat	e St.	ace of Dieno	eition /Nan	na of	1	Dat		20- 1	continu City or T		hr
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Ba	permit. Departr Importe any inju	g.	1 Mars	nc o	chil)	0945	I F	REHA	RT-	ECHO1	LS F			IOME, P.A		
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Record	e law re has be	Completed										24a. Was a		24b. Were auto	psy findings availal mpletion of cause of	ble
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Sic	ttend death stor: ,	icat	2 Accident	investigation 6 Could not be		niun/ - At hon	no farm etc	M cot factor		Yes 2 □ No		Location (S	Stroot an	d Number or Rura	I Pouto Number	
Division	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	Certification:	4 Homicide	determined	building,	etc. (Specify)	ne, rann, sur	et, ractory	, office		201	City or Tow			i noute rumber,	
	spital lours neral		29a. Certifier 1	Certifying Ph	ysician: To the bes	st of my know	rledge, death	occurred a	at the tim	e, date and	place, and	due to the o	cause(s)	and manner as s	tated.	
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1	NB 10:		12070		ine Cen		Wa 10	2015	M	D 2	1060	, 2				
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State of Maryland / Department of Health and Mental Hygiene 004 1 - For State Registrar 34867 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 13, 2004 **Physician** Henry Schemanski 10:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Nursing Home Anne Arundel Millersville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 9-14-1914 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Funeral **XX**M 2□ F Months 578-38-6978 Yrs 90 Director Pennsylvania Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21037 1615 Ruxton Rd. USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 21 No Specify: þ 3 Widowed 4 Divorced Year or Dates: 1943-46 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Claims Examiner Pages 1 and 2 should be filed w trnent of Health and Mental Hygier tant: If item 27 Is marked other tl jury or other traumatic event, In Insurance other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Schemanski Jenny (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathryn A. Schemanski/ Wife 1615 Ruxton Rd. Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c, Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 10-15-04 Edgewater, MD 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature Funeral Service Licensee Unut 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC BLADDER CANCER **Physician** MONTHS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, and cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to (or as a nonsequence of) Examiner requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ARTERY DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 XNaturai 5 Pending investigation 1 Tes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide within 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 031136 OCTOBER 13,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KILBRIDE RD., BAUTMORE, MD 21236 9005 Mu) 31. Date filed (Month, Day, Year) State OCT 1 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 004 34868 Registrar AMEND ITEM #2 PER PHY C840 2/1651/166ate of Death Reg. No. 2. Date of Death 3. Time of Death October Day **Physician** 2004 Lucille 2:00 A M Peggy Salomonson /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges 2812 Spindle Lane Bowie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2\ F Yrs. 426-82-4026 60 Director 1944 Feb.11, Mississippi Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other then "netural; or items 23e or 28a-f show 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County in then "netural", or items 23e or 28a-f show the Medical Exeminer must be notified at 1 XYes 2 No Director Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 2812 Spindle Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charlie Houston Swanner Bernice Hitt 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vincent V. Salomonson/ Husband 2812 Spindle Lane Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If any injury or other 10/23/2004 Greenlawn Cemetery Larimer, Colorado * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 1/2 years Immediate Cause (Final Colonic Carcinoma Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Quality (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown þ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2X No 3 Probably 4 Unknown Completed peed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed 1 ☐ Yes 2 ☐ No 2 🔀 No certificate t□ Yes the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner Hospital: Other: 4 Nursing Home 5 N. Residence 6 Other (Specify) 2 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA this After thi 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 1 XNatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a e Funeral I 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) ng title of certifier 29c. License number 29b. Signajure escurio. D19838 10/15/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selonick, M.D. 900 Bestgate Raod Annapolis, Maryland 21401 Stuart E. 31. Date filed (Month, Day, Year) 32. Agistrar's Signature State OCT 1820 Registrar

State of Maryland / Department of Health and Mental Hygiene 34869 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician Year 12:41 P M <u>Philo Agnes Sanders</u> October 13 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Olney
If Under 1 Year If Under 24 Hrs. Montgomery Montgomery General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🖫 F Months Days Hours Min Director 579-09-8889 Feb.21,1916 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f shot or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☑ No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 3640 Gleneagles Drive Apt. 3A Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene. Is marked other than "natural", or iter 1 Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Manager Clothing Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bernard Albert Clark Cora Elizabeth Drury 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 permit. Pages 1 and 2 sh Dep.rtment of Health and Imp.rtant: if item 27 is m any njury or other traum Frank J. Sanders Husband 3640 Gleneagles Drive #3A Silver Spring, Maryland 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cometery cromatory or other place)
te of Heaven
Cemetery 1 DBurial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Oct. 18, 2004 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service License Will 500 University Blvd.,W.,Silver Spring,MD 20901 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) et and Death where secondary to Cortalunde **Physician** /Medical Due to (or as a consequence of) Osspua Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence/of): Examiner attending physician and for use as the burial-transit certificate be executed Kace that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 🗆 Other (specify) signed by the a d be detached f detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 € No Inpatient 2 2 ER/Outpatient 3 DOA ctor: After this y the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 5 Pending investigation after death. М 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Nus MI 1> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Soulevord SIVER Seving Manford 20806 WARREN O FER LIS MD. 3305 Nova herseve World 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 18 2004 Registrar

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			1 - For State Registrar	State of Maryland	d / Depa <i>Cer</i>	artment of H	ealth and Death		giene ()	04 34	871
	Physici /Medic		1. Decedent's Name (First, Middle, La	silva				2. Date of De. Octob	Day /		700 AM
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	Director		216-78-8271 Usual Residence of Decedent 10a. State 10b. County		4 Yrs.			Dec. 5,	1939	Hondura	de City Limits
	death with the Maryland ms 23a or 28a-f show rmast by multified at	Director	Maryland Montgo		Censing	rton .				1 🗆	Yes 2x No
	h with t		10e. Street and Number 3615 Calvend Lar	ne.		10f. Zip Code 20895				What Country?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Programment of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-1 show any Injury or other traumatic event, the Medical Examination and Longe.	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.: Armed Forces? 1		Was Decedent of His Yes, specify Cubar Yes 2 No				ce - American India ack, White, etc.	
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Mary	d 2 shou h and M 7 Is mar traumat	-	19a. Informant's Name/Relationship (g Address (Street a	nd Number or Ri	ural Route Numbe	er, City or Town		
nore, r	Pages 1 and nent of Health int: If item 2 iry or other 1	La	Rosaly J. Vanders 20a. Method of Disposition **Burial 2 Cremation 3 Control (Special Cont	20b. Pl	lace of Dispos gmetery, crem Gate O	Birkenhe sition (Name of patony or other place the Deaven	Octo	ber 19,	20c. Location	- City or Town, Sta	
раншо	permit. P Departm Importar any Injur		21. Signature of Funeral Service Lice		Ceme Fra 50	cery Name and Address ancis J. O Univers	of Facility Collins	Funeral	Home I	nc.	en-1925
1	Physician /Medical		23a. Part 1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hepa+i	C F	ar the more of dying	, such as cardia	c or respiratory ar	rest,		ximate al Between and Death
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,0070	certificate be executed iding physician and ise as the burial-transit	dical Examine	is any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to or as a consequ	ience of):	' inte	ction)		ly	ear
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ר ה ה	w requires that the second sec	by P	Part II Other significant conditions	contributing to death but not resu	ilting in the ur	iderlying cause give	n in Part I.	23e. Did to	_/	stribute to the cause	e of death?
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	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	edical	(Check only one)	nysician: To the best of my knowniner: On the basis of examinat and marnar stated.	wledge, death ion and/or inv	estigation, in my opi	nion, death occu	e, and due to the curred at the time, c	ause(s) and m date and place,	anner as stated. and due to the cau	150(5)
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			Registrar 1. Decedent's Name (First, Middle, Las	')	Cen	tificate of E	Jeath	2. Date of Deat	eg. No.	3. Time of Death
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1	yland		10a. State 10b. County	10c. Cit	ty, Town or Loc	ation		• •		10d. Inside City Limits
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036	urs af	þ	3 Widowed 4 Divorced	1 Yes 2 No 194 If Yes, Give Year or Dates: 19	46	Yes 2 No	Specify:		Specify: Q I	acK
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Baltimore,	Se ju		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20b. F	lace of Disposi	atory or other place	,)		20c. Locyton - In or	Town, State
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	To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	edicai	(Check only 2 Medical Exem)	sicien: To the best of my kno- ner: On the basis of examinat	wiedge, death o	occurred at the time	, date and place, ar	nd due to the car	use(s) and manner as	stated.
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			30. Name and address of person who co	impleted cause of death (Item	23a) /Tunn Pr	int)	1102		112/0	/
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Stanford

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	/Medi Examir		4a. Facility Name (If not institution, give street and number) Doctor's Hospital	4b. City, Town, or Location of Death Lanham	-	Ac. County of Death Prince George's
	Funeral Director		5. Social Security Number 578-48-2564 Usual Residence of Decedent	hday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	B. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
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ë,	permit. Fages 1 and Department of Health Importent: If item 27 eny injury or other trong.		1 Burial 2 □ Cremation 3 □ Removal from State cemetery		/2004 wart Fune	Location - City or Town, State Suitland, MD eral Home
	nysician /Medical Examiner		23a. Part 1. Enter the disease, or compileations that caused the death. Do no shock or heart failure. List only one cause on each line. Immediate cause (Final disease or condition resulting in death) a. Due to (or as a consequence of	- bleed		Approximate Interval Between Onset and Death
8/60,	dean connicate be executed e attending physician and of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate course. The Library in Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of d.			
O. Box 6	attending for use a	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
cords, P.O	been signed by the should be detached	by P	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 Unknown
L Kec	2 5 0	e Completed	Nypertension 25. Was case referred to medical		24a. Was an autopsy performed? 1 Yes 2 N	24b. Were autopsy findings available prior to completion of cause of death? 1 \[\text{Yes} \] 2 \[\text{No} \]
0	After fune	ertification; To Be	examiner? 1	me of 28c. Injury at 28c work? M 1 □ Yes 2 □ No	5 Residence d. Describe how inju	ny occurred nd Number or Rural Route Number,
	within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical Cerl	29a. Certifier (Check only one) Wedicel Exeminer: On the basis of examination and/one) Wedicel Exeminer: On the basis of examination and/one and manner stated.	death occurred at the time, date and place, and or investigation, in my opinion, death occurred	City or Town, Stated due to the cause(s at the time, date an	and manner as stated
1	withi	W	29b. Signature and title of certifier	29c. License number M AD 6/1/3/	ceru	ate signed (Month, Day, Year)
4	Sta	to.	30. Name and address of person completed cause of death (Item 23a) (Ty HeG+Wer Hollowell 575 NJA/A 31. Date filed (Month, Day, Year) 22. Registrar's Signature	ype, Print) D 57K5ET 5017E 35	57 LAU	(EC, MD 20707
	Registr		OCT 1 9 2004 Seeder & Sp	arti		

			For State Registrar	State of Ma	arylan		artment of H rtificate of		Mental Hygi	iene 001	34874
Ph	ysici	an	1. Decedent's Name (First, Middle,	Last)					2. Date of Death Month		3. Time of Death
	/ledic			11500					October	17,20	7 1 Cmm A M
Ex	amin	er	4a. Facility Name (If not institution,			,		r Location of Death	1	4c. County of D	eath
	_		5. Social Security Number			1tc last birthday)	If Under 1 Year	mo/c If Under 24 Hrs.	8. Date of Birth	NA	
Fun Dire			214–92–0898 Usual Residence of Decedent	1□ M 2只 F	34	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 09/28/19		Birthplace (State or Foreign Country) ryland
/land	12		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
Man	Deili	tor	Maryland Oueen	Anne's	Sı	udlers	ville				1 ☐ Yes 2√∑No
ith the	DEL TAN	Olre	10e. Street and Number				10f. Zip Code		10	g. Citizen of What	Country?
ath w	MBL	ral	163 Teats Branch				21668			JSA	
ING 21215-UU36 be filed within 72 hours after death with the Maryland ital hygiene. Indougher than "naturel", or items 23a or 28a-f show	NAC STREET	by Funeral Directo	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 Yes, Give If Yes, Give			Was Decedent of H If Yes, sp <i>eci</i> fy Cuba 1 ☐ Yes 2☐,No	lispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	Black, W	merican Indian, hite, etc. White
2 bot	cal E	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occur	ation	1	6b. Kind of Busine	
Z1Z15-UU36 d within 72 hours af giene. r than "naturet; or	Day Wed	Completed by	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5	i+)		kind of work done DO NOT use retired Technici	during most of world)		Plastic	·
Hygir Physical	ent, t	e Co	12 17. Father's Name (First, Middle, L.	ast)		COTOI	1eciniici		e (First, Middle, M		
Maryland d 2 should be file th and Mental Hy 7 is marked oth	tic ev	To Be	Donald Grier						Kutchman		
2 shot and h	вши		19a. Informant's Name/Relationshi							City or Town, State	
C = 44	her tr		William R. Touls	on/Husband	1	-		-		ville, MD	
Se to			20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of Control		, c	ametery, crei	sition (Name of matory or other place ille Ceme	e) l		oc. Location - City Sudlersvi	· ·
baltimo permit. Page Department (Importent: If	any in once.		21. Signature of Funeral Service Li	censee		Fe ²² 37	LIOWS, HE W. Cypr	elfenbein ess Stre	& Newnam et, Milli	Funeral	Home, PA
			23a. 7 rt1. Enter the disease, or chock, or heart failure. List of	omplications that caused only one cause on each lir	the death	. Do not ent	er the mode of dyir	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between
Physic			Immediate Cause (Final disease or condition	_a acute	. m	40100	enous 1	eukemi			Onset and Death
/Medi Exami			resulting in death)	Due to (or as	a consequ	ence of):					70.7.50
		er	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a	a consequ	ience of):					
uted	ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events			,					
og / ou, cate be executed physician and	rial-tr	Еха	resulting in death) Last	Due to (or as a	a consequ	ience of):					
8/6U cate be e	he bu	dlcai		d							
		0 1	IF FEMALE:	"		dia and the					
cords, P.O. BOX or wrequires that the death certification been signed by the attending	ched for us	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnancy Other <i>(specify)</i>			23d. Date of d Month	lelivery Day Year
ords, F.C. requires that the	e deta	by Pt	Part II. Other significant condition	s contributing to death bu	ut not resu	liting in the u	nderlying cause give	en in Part I.	23e. Did toba	icco use contribute	to the cause of death?
cords w require been sig	plno								1 🗆 Yes	2 No 3 1	Probably 4 Unknown
d) a a	N	ompleted							24a. Was an	24b. Were	autopsy findings available o completion of cause of
The The	director, page	Сош							autopsy performe	ad? death'	es 2 No
VICAL P ilcian: Th certificate	actor,	Be (25. Was case referred to medical examiner?					26. Place of Deat	h (Check only one)		
Of VITA Physician: this certific	al dire	5	1 Yes 2 No	Hospital: Inpatier		R/Outpatien		4 Nursing Ho		ce 6 □Other (Sp	ecity)
ding h. After	funer	ertification:	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	28c. Injun Worl	/at <br Yes 2 □ No	28d. Describe how	injury occurred	
deat ctor	y the	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of Inju	ıry - At ho	me, farm, str		143 2 140	28f. Location (Stre	et and Number or i	Rural Route Number,
s after	o pe	Cert	4 Homicide determin	building, etc	. (Specify)			City or Town,	State)	
To the Hospital or A within 24 hours after To the Funerel Dire	completely filled in by the	edical (29a. Certifier (Check only one) Certifying Medical Ex	Physician: To the best of caminer: On the basis of and manner sta	examinat	vledge, death ion and/or inv	occurred at the timestigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, date	se(s) and manner a e and place, and do	as stated. ue to the cause(s)
To the within	Com	ž	29b. Signature and title of certifier				29c. License		290	d. Date signed (Moi	nth, Day, Year)
			· ('W	MD			PIL	553	Oc	tober 17	, 2004
			30. Name and address of person with CARCIE SUN					Hinore	ND 21	751	
	Staf	te	31. Date filed (Month, Day, Year)				37 Da	more	1.12 4	21	
Re	gistra	ar	001 10 20			-					

State of Maryland / Department of Health and Mental Hygiene

					a. y lai la	Cert	ificate c	f Death	oma.r.j	Reg. N		Ly ,	548	10
	Blooming		1. Decedent's Name (First, Middle, La			<u></u>		2. Date of D	eath		Van	3. Time	ot Death	
	Physici /Medio		Raymond Star	nley Tich	nell				Octobe	≥r ž	ey 20 20	Year 004	3:00) AM
	Examir		4a Facility Name (If not institution, gi						r Location of Dea		c. County			
			2906 Chestnut Gi					Swanton			Garre	ett		
	Funeral Director		214-36-9040		ge (In yrs. Ia 69	st birthday) Yrs.	If Under 1 Ye Months Day			rth ay Yea 4 1	935	9. Birthp Coun Mary	lace (State try) Land	or Foreign
	P 2		Usuel Residence of Decedent 10a. State 10b. County		100 City	Town or Loca	tion							
	Aenyls f shor	٥	MD. Garret	t.		wanton						1	0d. Inside (S 2021 No
	18 th	5	10e. Street and Number		1		10f. Zip Code	4		10a C	litizen of V	What Coun	ntry?	
	eth with the Merylan 123e or 28a-f show	ral Di	2906 Chestnut	Grove Ro			215	61		U	nited	d Sta	tes	
020	is 1 end 2 should be filed within 72 hours efter deeth with the Meryland of Health end Mentel Hygiene. Item 27 is marked other then "neturel, or items 23e or 28e-f show other treumstic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2XMarried 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			as Decedent of Yes, specify C ☐ Yes 2万万	f Hispanic Origin? (uban, Mexican, Pue lo <i>Specify:</i>	Specify Yes or Norto Rican, etc.)	0-	Blac	e - Americ ck, White, white, whit	etc.	
5	72 h	Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)		16a. Decede (Give ki	nt's Usual Oco	supation ne during most of we red)	orking	16b.	Kind of Bu	usiness/Ind	Justry	
12		훁	Elementary/Secondary (0-12)	College (1-4or	5+)	_	O <i>NOT use r</i> et M C L	red)		F	armir	act		
7	hed v her ti	ខ	unknown	1		- ar	IIICI	40 14-14 - 4- 14-	(Fire bald to	l				
and	ntel H	Be	17. Father's Neme (First, Middle, Last Irvin Stanley		1				ame (First, Middle		n Sumam	ie)		
Ē	d Mer d Mer mark	ဥ	19a. Informant's Name/Relationship		L	10h Mailin-	A dd (C4	Edit			T	0.4 7:-		
Z	d2s then Ter	- 1	Betty Tichnell/ w		4			t Grove R			•		/	561
ē,	ages 1 end 2 ant of Health e t: If Item 27 le y or other trei	-	20a. Method of Disposition		20b. Pla	ce of Disposit	ion (Name of		Date			City or To		201
Baltimore, Maryland 21215-0020	permit. Pages Department of I Important: If Its eny Injury or or phce.		14 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y)		ner Ce	metery		2004	Swaı	nton,	, Mar	yland	
Bal	Depar Impor eny Irr pnce.		21. Signature of Funeral Service Licer	Sol	ch St., W		rt,			215	62			
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. ne.	Do not enter	the mode of d	ying, such as cardia	ac or respiratory a	rrest,		1	Approxima Interval Be	tween
3	Physician /Medical		Immediate Cause (Final									į	Onset and	Death
	Examiner		Immediate Cause (Final disease or condition resulting in death)	a Multip	le Mye	1oma						6	mont	hs
		5	,		Due to (or a	as a conseque	ence of):					1		
	ficate be executed physicien end is the burial-transit	Examiner		b						_				
ć	the death certificate be executed by the attending physicien end ached for use as the burial-transit	Ž	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (or e	s e conseque	ince or):					1		
68760,	ysicie bur	edical	trat williated events	C	Due to (or a	s a conseque	uce of).					-		
68	entificat ding phy se as th	₽ M	resulting in death) Last		Due to (er u	s a conseque	1100 017.					-		
Box	aath cer attendir for use			d								<u> </u>		
Ε.	deat of fo	흥	Part II. Other significant conditions of	ontributing to death be	ut not resulti	ng in the und	erfying cause	given in Part I.	23b. Did	tobacc	o use con	ntribute to	the cause	of death?
P.0	that the da	Physician/	Coronary Arte	ry Disease	2				10	Yes :	2. No	3 ☐ Prob	ably 4] Unknown
	8 5 6	2				-								
Records,	e law requires that has been signed b ya 2 should be det	Completed	Congestive He	art Failu	re				24a. Was	an auto med?	opsy	ava	re autopsy ilable prior npletion of i leath?	to
<u>ac</u>	ata h page	등							101	fes 2	0	10	lYes 2□] No
<u> </u>			25. Was case referred to medical examiner?						ath (Check only o					
\leq	2 00	2	1 ☐ Yes 2 ☐ No			NOutpatient		ther: 4 Nursing I	Home 5 Resid	dence	6 □Othe	er (Specify,)	
ב ב	frer t	ë	27. Manner on th Naturel 5 ☐ Pending	28e. Date of Injur (Month, Day	y Year) 21	Bb. Time of Injury	28c. In		28d. Describe	how inju	iry occurre	ed		
S.	Attending Phy or death. ector: After thi by the funerel	cat	2 Accident investigation 3 Suicide 6 Could not b					Yes 2□No						
$\overline{}$	after death Director: / d in by tha	Certification:	4 Homicide determined	28e. Place of Inju- building, etc	ury - At home c. <i>(Specify)</i>	e, farm, street	t, factory, offic	9	28t. Location (a City or Tou			∍r or Rural	Route Nun	nber,
-	Hoepl 4 hou Funer taly fil	edical C	29a. Certifier Certifying Ph (Check only 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	edge, death o	ccurred at the tigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time,	cause(s date an	and mar d place, a	nner as sta ind due to	ited. the cause(:	s)
	within 2 To the comple		29b. Signature and title of certifier				29c. Lice	nse number	_	29d. Da	ate signed	(Month, D	Pay, Year)	
	> F U		→ 11/	Hm	~		1	71233	3	1	0/	20,	104	~
			30. Name and address of person who	completed cause of de	eath (Item 2						,			7
			Dr. Thomas John	son 311. N	1. 4th	st. (Dakland	, Marylar	nd 21550)				
I	Stat	e	31. Date filed (Month Day, Year)	2004 32. Registre	er's Signatur	A.	made a					~		

			1 - State of Maryland / Department of Health and Certificate of Death		ene 004	34876
8	Physici	an	1. Decedent's Name (First, Middle, Last) Doris Beverley Tierney-Holly	2. Date of Death Month	Day Year	3. Time of Death 4 14 PM
	/Medic Examin			eath O	4c. County of Death	7 1 1
			Carroll Hospital Center Westminster		Carrol	1
	Funeral Director		5. Social Security Number 215-50-1345 6. Sex 1 M 2 4 F 80 Yrs. Social Security Number 1 Months Days Hours Mi		1924 New	lace (State or Foreign htry) Zealand
	rytand how		10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	ha Ma 28a-f g	Director	MD Carroll Sykesville			1 Tyes 2 No
	3a or 3			10	g. Citizen of What Cour USA	ntry?
920	hours after death with the Maryland turel, or Hems 23e or 28e-f show al Exer it et must be indiffed et	by Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Sive 1 Yes, Give 1 Yes Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 Yes, Give 1 Yes Origin?	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
Maryland 21215-0036	72	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of w	working 10	6b. Kind of Business/Inc	dustry
121	within ane. then	ompi	Elementary/Secondary (0-12) College (1-4or 5+) 12 College (1-4or 5+) Secretary		Banking	
nd 2	Hyge #	BeC	17. Father's Name (First, Middle, Last)	lame (First, Middle, Mi	aiden Sumame)	
yla		To	Arthur J. Toon Dori	s Johnson		
Ma	d 2 h a 7 ii		19a. Informant's Name/Relationship (Type, Print) James Tierney-Holly/Husband 7200 Third Ave.			
Baltimore,			20a. Method of Disposition Description Community	Date 20	Oc. Location - City or To	wn State
Baltii	permit. Pages 1 Dep rtment of H Importent: If ite any njury or ot once.		21. Signature of Funeral Service Licensee AREHART—ECHOLS MO0945 P.O. Box 567 La	FUNERAL	HOME, PA	M M
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardi shock, or heart failure. List only one cause on each line.			Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		C	Onset and Death On Dir b
l	Examiner	ner	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Colits		Dans
,8760,	cate be executed physician and the burial-transit	dical Examiner	resulting in death) Last Due to (or as a consequence of):			
O. Box 68	eath certifi attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
S, P.	w requires that the d been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death out not resulting in the underlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to th	
Vital Record	The law ate has b page 2 s	Completed		24a. Was an autopsy performe	prior to con death?	osy findings available apletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical 26. Place of De examiner?	eath Check on one		
of	ding Phys Ih. : After this funeral di	ion: To	1 sinpatient 2 EN/Outpatient 3 DOA 4 Nursing	Home 5 Residence 28d. Describe how	ce 6 ☐Other (Specify injury occurred)
Division	ten deal tor the	ertification;	2 Accident investigation 3 Suicide 6 Could not be determined determined M 1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,
_	Hospita 4 hours Funerel ely filled	edical C		ce, and due to the caus curred at the time, date	se(s) and manner as sta a and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier 29c. License number		Date signed (Month, D	Day, Year)
(085	10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Time than Kushnt IIY Business (Mtv 31. Date filed (Month, Day, Year) OCT 1 9 2004 32. Rigistrar's Signature	Drive G	2016 (18/2) 2016 (18/0m)	MD 2/136
	Sta Registr		31. Date filed (Month, Day, Year) OCT 1 9 2004 32. Egistrar's Signatur	•	***************************************	

			1 - For State Registrer	State of M	aryland / Depa <i>Ce</i>	artment o	of Health and		jier (2)	04	34877
	Dhunia		1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea Month		Year	3. Time of Death
	Physici /Medi		Guynel	Jeror	ne	To	olson	October	14, 2	004	10:46 P M
1	Examir	ner	4a. Facility Name (If not institution	-			vn, or Location of Deat	th	1	y of Death	
	-		Civista Hosp 5. Social Security Number		e (In yrs. last birthday)	LaPlat		. 8. Date of Birth	Char		place (State or Foreign
l	Funeral Director		216-22-2706 Usual Residence of Decedent	1 X M 2□ F	77 Yrs.	Months Da	ays Hours Min. Sep		, Year)	Mary	ntry)
	yland		10a. State 10b. County	1	10c. City, Town or Lo	ocation				Ţ.	10d. Inside City Limits
	a-fel	ctor	Maryland Charle	es	Waldorf	Ī					XXYes 2 ☐ No
	or 28	Director	10e. Street and Number			10f. Zip Cod		1	0g. Citizen of	What Cou	ntry?
	s 23e	erai	14870 Tolson I		5 in H.S. Jan	2060			USA		
36	be filed within 72 hours after death with the Maryland tial Hygiene. od other than "natural", or llems 23e or 28e-f ehow event, the Medical Examinar must be notified at	by Funerai	11. Marital Status 1 □ Never Married 200 Mai	. If *Yes, Give	_{No} 1946–	Was Decedent If Yes, specify (1 ☐ Yes 2√2	of Hispanic Origin? (S Cuban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)		ick, White,	
21215-0036	hour fural		3 ☐ Widowed 4 ☐ Divorce	Year or Dates:	1947	dent's Usual O			16b, Kind of E	BI	ack
15	n na	Completed	(Specify only highe	est grade completed)	(Give	kind of work do DO NOT use re	one during most of wo	rking	160, King of E	susiness/in	dustry
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or	Exp.	losion	Handler		Federa	l Gov	ernment
	al Hygie I other	Bec	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle, I	Maiden Suma	me)	
yla	should be fand Mental I s marked of umatic eve	10	Rudolph		Lson		Martha		McPher		
Maryland	Cd — m		19a. Informant's Name/Relation:				reet and Number or Ri				
	of Health item 27		Lucille Tolso	on/ Wife	14870 20b. Place of Dispo		Place Wal		ryland 20c. Location		
Baltimore,	00-		1X Burial 2 ☐ Cremation		cemetery, crei	matory`or other	place)				
ij			4 ☐ Donation 5 ☐ Other (521. Signature of Funeral Service		St.Mary (10/2	1/04 E	sryanto	wn,Ma	ryland
B	permit. Departr Importe any inju		Delessa Oy				neral Home	P.A. Ac	บลรดด.ไ	Marvl.	and
~	1 14		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that caused	the death. Do not ent						Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition	an	11	12-6	ant f			- 1	Onset and Death
	/Medical		resulting in death)	aDuy to for as	a consequence of);	2000	4 >10				1011/44
	Examiner		Sequentially list conditions,	b. Hego	er trus 10	N					Lepr,
	pe isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (ciscass or injury that initiated events	Due to was	a consequence of):	7-1-	CorpioVX	and low	15	leage of	V
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):	565 (MANONE	500 100	1/50	250	1881
8760,	icate be execute physician and s the burial-trans	dical E		d							
9	death certificate be executed e attending physician and of for use as the burial-transit	edic		0.							
Вох	eath certific attending p for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Tenasia araas			23d. Da	ite of delive	∍ry
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at		Ectopic pregna Other (s <i>pecif</i> y			Mo	onth	Day Year
P.O	at the de t by the a stached	Phys	9 Unknown								
	The law requires that ite has been signed b page 2 should be deta	by	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the u	nderlying cause	given in Part I.		11		ne cause of death?
oro	w requir been s should	eted						1 Te	s 2 No	3 🗌 Prob	ably 4 Unknown
Records,	e law has b	Completed	-					24a. Was ar autops	У	prior to cor	psy findings available mpletion of cause of
alF									No	death? 1 ☐ Yes	2 🗆 No
Vital	5 S S	o Be	25. Was case referred to medica examiner? 1 \(\text{Yes} \) 2 \(\text{N} \) No	Hospital:	A PERIODE		Othor	ath Check on one			
of		H- 1	27. Manner of Deat	1 ☐ Inpatie	ry 28b. Time of	I J DOA	njury at Work?	lome 5 Reside 28d. Describe ho			y)
ion	Attending I r death. ector: After by the funer	atio	1 Accident 5 Pendi	ng (Mo <i>nth, Da</i> igation	y Year) Injury		Work? 1 ☐ Yes 2 ☐ No				
Division	in Direct	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		ury - At home, farm, str c. (Specify)	eet, factory, off	ice	28f. Location (Str City or Town	reet and Numb , State)	oer or Rura	I Route Number,
	Hospite 4 hours Funerel ely fillec	Medicai C	29a. Certifier 12 Certifying cone) 12 Medical	ng Physician: To the best Exeminer: On the basis o and manner st	f examination and/or in	n occurred at the	e time, date and place ny opinion, death occu	, and due to the ca rred at the time, da	use(s) and ma	anner as st	tated.
	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifie			29c. Lic	ense number	29	9d. Date signe	d (Month,	Day, Year)
	- > F ()		70	MX	1 mi	1	MADE		Oct		
(1		30. Name and address of pers in	who completed cause of d	eath (Item 23a) (Type,	Print)	1010100			17 6	CONT
1	BIM	, N	TI F14) 1	201 M)	2 11	platero	& MID	20601			
	Sta		31. Date filed (Month, Day, Year	9 2004 32. R distr	ar's Signature	how all a	1	-			
	Registr	ar	0011	O LOUT A	A TONE DE SE	The same of the sa					

			1 - For State Registrar	State of I	Maryland / D	epar <i>Cert</i>	rtment of Herificate of L	ealth a D <i>eath</i>	nd Me		ene	004	34878
			1. Decedent's Name (First, Middle, Las	it)					2	. Date of Death Month			3. Time of Death
н	Physici /Medio		Marilyn Hyde T	oher					0		Day 18,	2004	10:20 p M
	Examir		4a. Facility Name (If not institution, give		er)		4b. City, Town, or	Location of	Death		4c. C	ounty of Death	
п			Calvert Memori	al Hospi	tal .		Prince :	Frede	rick			Calver	t
	Funeral		5. Social Security Number 6. S		Age (In yrs. last birt		If Under 1 Year Months Days	If Under 2	4 Hrs. 8 Min.	Date of Birth (Month, Day,	Year)	9. Birth	place (State or Foreign
	Director		048-24-4322	LIWI ZIALF	71	Yrs.			3	3/4/1933	3		MD
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Loca	ation					- · · · · · ·	10d. Inside City Limits
	Manyi f sho	ō	3400										1 X Yes 2 □ No
	the /	Director	MD Calv	ert			Dunkirk 10f. Zip Code			100	n Citize	n of What Cou	intry?
	3a or	Ö	1700 Cavalier	Torrago				754			3	USA	,
	death	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Wa	as Decedent of His	panic Origi	in? (Specif	fy Yes or No-	14	. Race - Amer	ican Indian,
က္	or Iten		1 Never Married 2 Married	Armed Force		lt.	Yes, specify Cubar	ı, Mexican,	Puerto Ric	can, etc.)		Black, White	, etc.
ğ	al', d	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Date	s:	11	□Yes 2 X No	Specify:			S	pecify:	White
2-0	72 hours after death with the Maryland hatural', or Items 23a or 28a-f show dical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest gra		16a.		int's Usual Occupa		of working	16	6b. Kind	of Business/I	ndustry
7	within ene. than "	oldu.	Elementary/Secondary (0-12)	College (1-4d		life. DO	O NOT use retired)						_
2	e filad within al Hygiene. I other than " vent, Ire Mo	ပ္ပ	12		T	eler	ohone Ope					Hospita	31
Ind	be fi	Be	17. Father's Name (First, Middle, Last)					18. Mother	's Name (F	First, Middle, Ma	aiden Su	ımame)	
<u>Y</u>	should be ind Mental s marked umatic ev	²	Howard Eaton						lary F				
Maryland 21215-0036	0 0 0		19a. Informant's Name/Relationship (7	,, ,			Address (Street a						
	1 and 2 Health tem 27 i		Sharon Calhoun/Da 20a. Method of Disposition	ughter	20b. Place of	_	Cavalier	Terr	ace,				
altimore,	ges or of B		1 ☐ Burial 2 [XCremation 3 [X		comoton	y, crema	atory or other place	· I				tion - City or T	
ΪŢ	t. Pa rtmer rtant riury		' 4 □ Donation 5 □ Other (Specify		Sever					2004 Pi	cinc	eton, I	WV
Ba	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other 9000.		21. Signature of Funeral Service Licen	ov			Name and Address D Box 430	,	Rā	aymond-W , Maryla	vood and	Funera 20754	al Home, P.1
Т			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caus	sed the death. Do n								Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	META	STATIC		Color	10	AN	CER			Onset and Death
	/Medical		resulting in death)	Due to (or	as a consequence of	of):			-1 11			-	20015
ď	Examiner		Sequentially list conditions,	b									
	P #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of	of):							
	ecute and -trans	cam	that initiated events resulting in death) Last	c									
8760,	cate ba executad bhysicien and the burial-transit		rosoning in doddin Last	Due to (or	as a consequence o	or):							
876	cate to	dicai		d									
9	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcor	no of programme.						1		
Вох	atten for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death		ctopic pregnancy				230	 Date of deliving Month 	ery Day Year
o.	the de	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	9☐ Unknowr	at time of death	2 🗆 (Other (specify)						
٥.	that the death led by the atter detached for r	Ph	Part II. Other significant conditions of	ontributing to death	but not resulting in	the und	ferlying cause giver	n in Part I.		23e. Did toba	cco use	contribute to 1	the cause of death?
ds,	uires tha signed d be del	d by			3		,			1 ☐ Yes			
Š	w requir been si should	ete											
že	has has	Completed							_	24a. Was an autopsy performe		24b. Were auto prior to co death?	opsy findings available empletion of cause of
a											No	1 Yes	2No
Vital Records,	ysician: The is certificate hadirector, page	Be	25. Was case referred to medical examiner?	Hospital: 'V'			Other			Check onle one			
	Physician: this certific ral director,	7	1 ☐ Yes No 27. Manner of Death	1 Inpa			3 DOX	4 IVUIS	-	5 Residend			fy)
u	ding h. After fune	tlon	Natural 5 Pending	(Month, I		njury	28c. Injury Work? M 1 □ Y	at Ps 2.⊟No		d. Describe how	irijury o	ccurred	
S	Attending It death. ector: After by the fune	lica	3 ☐ Suicide 6 ☐ Could not be		Injury - At home, far	m stree		63 2 110		Location (Street	et and N	lumber or Rur	al Route Number.
Division of	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	4 ☐ Homicide determined	building,	etc. (Specify)	111, 31100	n, ractory, office		201.	City or Town,	State)	amber of Har	ai noute ivaniber,
	spita Tours neral		29a. Certifier 1 Certifying Ph	ysician: To the be	st of my knowledge,	, death o	occurred at the time	a, date and	place, and	due to the cau	se(s) an	d manner as s	stated.
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in it	edical	(Check only 2 Medical Examone)	niner: On the basis and manner	s of examination and	Vor inve	stigation, in my opi	nion, death	occurred	at the time, date	and pla	ace, and due t	o the cause(s)
	To the within 2 To the complet	X	29b. Signature and title of certifier				29c. License	number		29d	l. Date s	igned (Month,	Day, Year)
) Stre	-OLS	2		DO	25	5519	7 1	0	-19-	- 2004
	A		30. Name and address of person who o	completed cause of	f death (Item 23a) (Type, Pr	rint)						,
_	4		Atul Shah, M.D.	110 Hosp	oital Road	d, P	rince Fre	ederio	ck, Ma	aryland	206	78	
	Sta		31. Date filed (Month, Day Year) QCT 2	32. Regi	ster's Signature		4						
	Registr	ar	001 2	V ZUU4	Genevas 1	5	House						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 34879 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Frances Orissa Temple October 13 4:00 a. 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mallard Bay Care Center Cambridge Dorchester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Days Hours Director 209-20-0509 80 March 7, 1924 Pennsylvania Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Dorchester 1 MYes 2 □ No Director Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 520 Goldsborough Ave. 21613 or Itams 23a U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No À Specify: 3 Widowed 4 □ Divorced white Year or Dates natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) presser 11 garment and Mental Hygie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Sumame) should be fi Be Samuel P. Coudriet Sadie Katherine Hetrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Pages 1 and 2 si Item 27 Marvin Samuel Temple son 520 Goldsborough Ave., Cambridge, MD 21613 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Ξ permit. Page Department Important: if any injury o East New Market Cem. 10/19/04 East New Market, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. Brin K. But 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Arteriosclerone Heart em resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) Examiner death certificate be executed and physicien ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as attending IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown à signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 240 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 → No has autopsy perform page this certificate 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 2 1 ☐ Yes 2 → Ro 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Medical Certification: or Attending 1 Matural 5 Pending within 24 hours ane,
To the Funeral Director: Aft investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

NOMAN

Will

THANWY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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CAMBRIDGE

10.13.04

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MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stete Registrar 34880 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** рм 12, Brian Tapp October 2004 1:30 Leslie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery 12314 Charles Road Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Oct. II, 1955 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months Days 1 1 M M 2 □ F 49 Director 216-68-1333 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiane. kher than "natural", or flems 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or than "natural, or Items 23a or 28a-f show the Medical Examinating the bandified at 1 ☐ Yes 2 ☑ No Director Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 20906 12314 Charles Road USA Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) 12 Transportation Manager Sunbelt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) should be fill and Mental H Be and Mental Willard H. Tapp Elizabeth J. Lanham ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh
Dep. rtment of Health and
Importent: If item 27 Is m
any injury or other treum Elizabeth J. Allen/Mother 11520 Patapsco Drive, Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other pla Gate of Heaven Date 20c. Location - City or Town, State 20a. Method of Disposition October 18 1 ⊠Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) 2004 Silver Spring, Marytand Cemetery 21. Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. Mu |500 University Blvd, W., Silver Spring, MD 20901 Part1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fall re. List only line cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Acute Myocardial Infarction 5 Minutes /Medical Due to (or as a consequence of): Examiner Coronary Artery Thrombosis
Due to (or as a consequence of): 5 Minutes Sequentially list conditions, if any, leading to immediate cause. Erner Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit Coronary Atherosclerotic Disease Unknown that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) 4☐ Pregnant at time of death 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Hypertension, Morbid_Obesity, Non-Insulin Dependent Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Diabetes Mellitus autopsy performed? 1 ☐ Yes 2 X No Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 \sum Nursing Home 51 Residence 6 Other (Specify) 2 1 Tes 2 No this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 27. Manner of Death 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) MIN D0009215 October 14, 2004 zwien 16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Lawrence D. Marcus,

18 2004

31. Date filed (Month, Day, Year)

OCT

sacks

M.D.

32. Registrar's Signature

regier

10313 Georgia Avenue, #207, Silver Spring, MD 20902

State of Maryland / Department of Health and Mental Hygien 2004 34881 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\overset{\text{Day}}{1}6$, $2\overset{\text{Year}}{004}$ Physician OCTOBER PHILLIP **JEROME** WHITEHURST, SR. 2:25 pM /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY CO. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
MAY 15, 1945 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1√ M 2□ F WASH. 577-62-9864 59 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "naturel", or Items 23s or 28s-f show The Medical Exercit retrieved by a calified at 1 TYes 2 □ No Director MD PRINCE GEORGES HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5902 85th PLACE 20784 U.S.A. death v permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel" or lineary injury or other treumatic even. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: δ 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECURITY GUARD 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THEODORE WHITEHURST AMEMIA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CYNTHIA WHITEHURST - WIFE 5902 85th PLACE, HYATTSVILLE, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ABurial 2 Cremation 3 Removal from State RESURRECTION CEM. 10-22-04 * 4 ☐ Donation 5 ☐ Other (Specify) CLINTON, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility TAYLOR S FUNERAL HOME DC 20001 NORTH CAPITOL ST. NW WASH 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, surfus cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed/ certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☑ No Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Vinpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title q certifie 29c. License number 30. Name and address of person who corneleted cause of death (Item 23a) (Type, Print) Ave., #205 Takoma 7610 Carroll Park, Nasheen Kango 20912 MD31. Date filed (Month, Day, Year) State OCT 1 9 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 0 0 4 34882 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical Dorothy Hance Williams

4a. Facility Name (If not institution, give street and number) 14 2004 4c. County of Death October | 9:20 A.M 4b. City, Town, or Location of Death **Examiner** Calvert 4005 Adelina Road Prince Frederick | Prince Fice | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare of Birth | Stare o 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Director 217-20-9458 80 Usual Residence of Decedent the Maryland 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show traumatic evant. The Medical Examiner must be nutified at 1 ☐ Yes 2√☐ No Maryland Directo Calvert 4005 Adelina Road 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Prince Frederick 20678 United States Itams 23a death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 72 hours after ☐ Yes 2 🔀 No Yes, Give 1 Never Married Married ٥ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7. In and Mental Hygiene. 7 is marked other than "na College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Sarah Lillian Hance Paul Laveille Hance 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Thomas H. Williams, Jr. (Husband) 4405 Adelina Rd., Pr. Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory 10/15/04 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee MOO542 4405 Broomes Isl. Rd., Port Republic, MD 20676 TT. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Colon Cancer year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to [or as a consiquence of]: Examine cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4☐ Pregnant at time of death 5 Other (specify) 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe Cerebovascular accident 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2 No Yes Hospital or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗀 Homicide 29a. Certifier 1 🗹 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal within 24 ho

To tha Fune

completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D16823 October 15, 2004 n who completed , se of death (Item 23a) (Type, Print) 30. Name and addres of or Robert J. Schlager, MD 110 Hospital Rd. #111, Prince Frederick, MD 20678 31. Date filed (Month, Day, Year) 32. Registras Signature State OCT 15 2004) Steen & Sparke Registrar

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				For State Registrar	State of Ma	aryland / [it of Health and e of Death	d Mental Hy	giene 0	04	34883
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6	1	Exami	iei	Peninsvla Region	//	af Cent	er _	Salisbury			icor	nsco
6646		Funeral Director		5. Social Security Number 6. S 213-22-9499 Usual Residence of Decedent	ex 7. Age □ M 2⊠ F 8	e (In yrs. last bir 7	thday) If Under Yrs. Months	1 Year If Under 24 H Days Hours M	Irs. 8. Date of Bi in. (Month, D 4 / 1 4	71917	9. Birthp Coul Vii	place (State or Foreign ntry) Cginia
22		ith the Maryland or 28a-f show	tor	10a. State 10b. County	omico	10c. City, Tow	n or Location Delmai				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
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8		death	nera	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13. Was Deced	dent of Hispanic Origin? offy Cuban, Mexican, Pu	(Specify Yes or N		ice - Americ	
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		For State Registrar	State of M	larylan		artmer rtifica			and Me		iene	004	34884
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Funeral Director		MALLARD BAY NURS 5. Social Security Number 220-18-4594			NTER last birthday) Yrs.		AMBR 1 Year Days	IDGE If Under: Hours	Min.	B. Date of Birth (Month, Day EPT • 2	Year)	RCHESTEI 9. Birthp Coun 26 MARY	ace (State or Foreig
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Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importantit if them 27 is marked other than eny injury or other traumatic event, the Ma	once.		21. Signature of Funeral Service I	. Stew	at II			Ber	nning	Rd.,	ewart I	lash.,		20019
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R (3)			30. Name and address of person	who completed cau	se of death (Iter	m 23a) (Type,	Print)			در سروس،	s lane	C1. W. S.	118	20777
	State		DICIAN DAYLY 31. Date filed (Month, Day, Year)	M.D. 7	Registrar's Signs	qNOVER	G FARI	KW1	4y 30	1166	, QKE	THE	1 110	- //-
(8)	state istrar		OCT 2 0 2	2004	en 1	An	W.							20770

State of Maryland / Department of Health and Mental Hygien 2 0 0 4 34886 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 15 Oct. 2004 2:30 P Lehman Henry Williams /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince Georges

9. Birthplace (State or Foreign
Country) N. Carolina Cheverly Prince Georges Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2□F 1932 Pollocksville Director 241.42.8805 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County r iteme 23a or 28e-f ehow insert, ust be notified at 1 XYes 2 No Director /Capitol Heights Maryland Prince Georges Seat Pleasant 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20743-2619 U.S. Α. 7208 Hasting Drive Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 MYes 2 DNo If Yes, Give KOT earl Year or Dates Conflict Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. Item 27 is marked other than "natural", or Ite wither traumatic event, the Madical Exerting. 1 Never Married 2 Married 1 ☐ Yes 2 🔼 No Specify Specify: ģ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Small Business Elementary/Secondary (0-12) Property Manangement Specialist Ac 18. Mother's Name (First, Middle, Maiden Surmame) Administration 17. Father's Name (First, Middle, Last) Be Daisy Adeline Parker Leo Vanderbilt Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other trat once. Marion D. Bridges Williams/ Wife 7208 Hasting Drive Seat Plesant Maryland 20743-2619 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Nov 2, 2004 Arlington Virginia * 4 □ Donation 5 □ Other, (Specify) Arlington National 22. Name and Address of Famility Latney's Funeral Home 21. Signature of Funeral Service Licensee D.C. 3831 Georgia Ave. N.W. Washington, 20011 art1. Fire r the disea *, or complications that caused the death, shock, a heart failure. List only one cause on each line. euler the mode of dying, such as carding or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use centribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No this certificate Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 npatient 1 ☐ Yes 2 🂢 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Many er of Death 1 X atural funeral late of Injury Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined Suicide
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 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 9 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature an Little of certifier 29c. License number and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL 3000(31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

1 9 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar 34887 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marjorie Golden Anderson Walker 13, October 2004 5:50AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park, Maryland Montgomery Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ☐ M 2 🖺 F 86 Yrs. Director 578-20-0733 1918 Feb. Washington, D.C Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits item 27 Is marked other then "natural", or Items 23a or 28a-f show other treumatic event, the Madical Examiner in unit to notified at Silver Spring 1⊠Yes 2□No Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20910 1220 East West Highway; Apt. 1107 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 23€ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene.
Is marked other then "natural", or Ite. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 12 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done do life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) 12 Statician Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Lucy Chloe Thomas Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Importent: If item 27 Is n any injury or other treum once. 3423 5th Street, SE. Unit #22; Washington, DC. 20032 Linda Walker/Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oct.19,2004 Suitland, MD. Lincoln Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes 5538 Marlboro Pike 21. Signature of Funeral Service Licensee 22. Name and Address of Facility wa Forestville, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** deu /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospitel or Attending Physiclen: within 24 hours after death.

To the Funerel Director: After this certifies funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner' 21 NO Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 MOBUND, HUNS 31. Date filed (Month, Day, Year) Registrar's Signature State OCT 1 9 2004 Registra

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		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H <i>rtificate of L</i>			en2 0 0 L	34889
	o Dharaini		1. Decedent's Name (First, Middle,	Last)				2. Date of Death Month	Day Yeer	3. Time of Death
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		٠	4390 Molton Dri		//	Mt. Ai		0.0 (0.1)	Frederic	
	Funeral		-	6. Sex 7. Age 1 1 1	e (In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign intry)
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	/land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
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	r 28g	irec	10e. Street and Number		1100111	10f. Zip Code		10	g. Citizen of What Cou	intry?
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	ems er il	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spender)	ecify Yes or No-	14. Race - Ameri Black, White	
36	or it	Y.F.	1 ☐ Never Married 2 ☑ Marrie	16 Van Chia	10	1 ☐ Yes 2 ☒ No	Specify:			nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modicel Extraigner must be multified at	d by	3 Widowed 4 Divorced	Year or Dates:		d- #- 151 O				
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<u>a</u>	lid be lenta ked ic ev	To Be	Warren D. Well	Ls			Ruth			
Maryland	12 should be filed within in and Mental Hygiene. 7 is marked other than "risaumetic evant, the Mad		19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili	ng Address (Street a	and Number or Rura	al Route Number,	City or Town, State, Zi	o Code)
	and 2		Regina M. Wells	3 / Wife		Molton Dr	ive Mour	nt Airy,	Maryland 2	1771
altimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	3 □Removal from State	20b. Place of Dispo cemetery, cre-	osition (Name of matory or other place	a)	ber 18,	Oc. Location - City or T	own, State
Ě	Pag ment ant:		`4 □ Donation 5 □ Other (Spe	ecify)	Frederic	k Cremato	rv	2004 F	rederick, l	Maryland
Ball	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumetic event, the Modical Extending to unit be multified at once.		21. Sign ture of Funeral Service Li	cense	2:	2. Name and Addres	s of Facility Sta	uffer Fu	neral Home	s, P.A.
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			23a. Part1. Enter the disease, or/c shock, or heart failure. List of							Approximate Interval Between Onset and Death
	Pnysician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 446	vosdero	tic bea	rdio va:	scular	disease	10 Years
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	uted d ansit	mir	Cause (Disease or injury that initiated events							
Ó	an ar	Ex	resulting in death) Last	Due to (or as	a consequence of):					
8760,	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical Examiner		d						
9	as as	Mec	IF FEMALE:	22- 14						
Вох	death certifica attending ph I for use as th	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant at	2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
o.	that the death cer ed by the attendir detached for use	ysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	time or death 5	Other (specify)				
_ "	res that I igned by be deta		Part II. Other significant condition	te contributing to death hi	ut not resulting in the u	indorhina onuna aus	a ta Bank I	II		
<u>α</u>			ant in outlot digitallocality outloans	is continuating to death be		indenying cause give	n in Part I.	23e. Did toba	cco use contribute to t	he cause of death?
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien? 0.01.

			1 - For State Registrar	State of Ma	ryland /		triment of F tificate of			leg. No.	J () 4	34890
	Physici	an	1. Decedent's Name (First, Middle, Las Walter Leroy		r				2. Date of Dea Month October		Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution, give		'		4b. City, Town, o	r Location of Deatl			2004 ounty of Death	6:45A [™]
			Northampton Manor	Health Car	re Cent	er	Fre	ederick			Freder	ick
	Funeral Director		2.0 00 2000	ex 7. Age M 2□F	(In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Dec. 22	Year) 192	9. Birthpi Coun Penns	lace (State or Foreign try) Sylvania
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox	vn or Lo	cation				10	0d. Inside City Limits
	a Mari	ctor	Maryland Frede	erick			Walkersv	/ille				1 No 2 No
	with th	Director	10e. Street and Number	#215			10f. Zip Code	01700		_	of What Coun	try?
	ns 23	eral	500 Chape 1 Cou	12. Was Decedent E	ver in U.S.	13. V	Vas Decedent of H	21793 Hispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		U.S.A.	an Indian,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importents if Item 27 is marked other then "naturel, or Itams 23a or 28a-f show any figury or other traumatic event. The Medical Exartinar must be rediffed at ODGE.	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0		Yes, specify Cuba	an, Mexican, Puèrt Specify:	o Rican, etc.)		Black, White, e ecify: Whi	etc.
50	"natur	eted	15. Decedent's Ed (Specify onfy highest gra	ucation de completed)	168	. Deced	lent's Usual Occup	pation during most of wor d)	rking	16b. Kind	of Business/Ind	lustry
72	within ene. then '	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. L	oo NOT use retired fore			е	lectror	nics
מק	e filed al Hygi othar vent, I	Be Co	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Maiden Sui	mame)	
ylar	ould b Menta arkad	ToE	Stewart Willia					Cora	Lucinda	Pitt	inger	
Mar	d 2 sh th and 7 Ism traum		19a. Informant's Name/Relationship (7) Elizabeth M. Weic					and Number or Ru Ct., #215			le, MD	
<u>ნ</u>	s 1 and f Heali fem 2 other		20a. Method of Disposition				sition (Name of natory or other place		_		ion - City or To	
Baltimore,	iit. Page: artment o ortent: If injury or 1.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fuperal Service Licen)	Rocky	Hil	1 Cemete	ry 10/1				o, MD
æ	Depar Depar Impo any It		1 athanine). Xlan De	er	1	104 S. Ma	^{ss of Facility} Ha in St.,	Woodsb	unera oro,	I Home MD 2179	18
	11		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused one cause on each line	the death. Do	not ente	er the mode of dyin	ng, such as cardiac				Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ASP			JOUNGAI	A				Onset and Death
	Examiner		Sequentially list conditions,	b								
	tad nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):						
o	execu in and rial-tra	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
68760,	ate be hysicia the bu	edical	(d								
	entific ding p		IF FEMALE:	23c. If yes, outcome o	foregoancy							
P.O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 2 4 Pregnant at t	Fetal deat		Ectopic pregnancy Other (specify)	1		23d.	Date of deliver Month	y Day Year
	s that pned b	by Pt	Part II. Other significant conditions of	ontributing to death bu	t not resulting	in the ur	derlying cause giv	en in Part I.	23e. Did tol	acco use	contribute to the	e cause of death?
ords	w requires that been signed to should be det		ALZHEIME	rs Demen	TIA	_			1 🗆 Y	s 2 N	o 3 🗆 Proba	ably 4 ∏Unknown
Vital Records,		Completed							24a. Was a autops perform	y ned?	4b. Were autop prior to com death? 1 \(\subseteq \text{Yes} \) 2	sy findings available apletion of cause of
/ita	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Lla anital:			- Cou.		th (Check only on			
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Division of	r Attending Physician: er death. rector: Aftar this certifics by the funeral director, to	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day		Injury	Worl	k? Yes 2 □ No	200. Describe III	W IIIJaly oc	,ou1160	
VISI	l or Attendater death Director: in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	y - At home, f	arm, stre	et, factory, office		28f. Location (St City or Town		umber or Rural	Route Number,
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	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	ledical	one)	ysician: To the best of iner: On the basis of and manner stat	examination at	e, death nd/or inv	estigation, in my o	pinion, death occu	rred at the time, d	ate and pla	ce, and due to	the cause(s)
	To To con	Σ	29b. Signature and title of contiller	1/ ~	`		29c. License	32171	2	ed. Date si	gned (Month, D	•
	2 2		30. Name and address of person who d	completed cause of de	ath (Item 23a)	(Type I		J < 1 (1		(0 181	04
	, S. B.		RICULARD GU	WCH MD	PO 6	י מדיים	328 4	ALKERS	ाराह्य /	20	2179	3
	Sta Registr	. 4	31. Date filed (Month, Day, Year)	32. Registrat	's Signature	L	1					
	ricgisti	an .	061 18	LUUH JULY	we L	1	goods					

			1 - State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death		eng 004	34891
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Lai Chun Yu		Oct.17,	2004	9:00 A ^M
	Examin	ier	4a. Facility Name (If not institution, give street and number) National Lutheran Home	4b. City, Town, or Location of Death		4c. County of De	
			5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	Rockville	8. Date of Birth	Montgom	
П	Funeral Director		325-58-7344 1□M ¾□F 77 Yrs.	Months Days Hours Min.	Dec. 5, 1		rthplace (State or Foreign country)
	P _		Usual Residence of Decedent		Dec.J, I	920 (<u>China</u>
	e Marylar a-f show	ctor	Md. 10b. County 10c. City, Town or Li	Rockville			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the	al Director	10e. Street and Number 9701 - Veirs Drive	10f. Zip Code 20850	10g	. Citizen of What C	ountry?
036	be filed within 72 hours after death with the Maryland nta! Hygiene. bd other than "naturel", or Items 23a or 28a-f show event, the Medical Exart are must be redified at	by Funeral	I ⊓ Never Married 2 TX Married I ⊓ Yes 2 TX No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 No Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify: Ch	ite, etc.
Maryland 21215-0036	within 72 ho ane. than "natur e Wedical	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) (Give life.	dent's Usual Occupation kind of work done during most of workir DO NOT use retired) OMEMARE	ng	b. Kind of Business	
and 2	be filed ntat Hygi od other event, I	Be	17. Father's Name (First, Middle, Last) Law Tam	18. Mother's Name	(First, Middle, Mai	At Home	
Maryl	s 1 and 2 should be f Health and Mental item 27 is marked other treumatic ev	၉	19a. Informant's Name/Relationship (Type, Print) Helen Yu-Daughter 19b. Mailii 19b. Mailii	ng Address (Street and Number or Rura. 15-Manifest Way	l Route Number, C	ity or Town, State,	Zip Code)
altimore,	Pages 1 and 2 ent of Health nt: If item 27 i ry or other tre		20a Method of Disposition 20b. Place of Dispo		ate 200	c. Location - City or	
Baltii	permit. Pages 1 Department of H Important: If ite eny injury or ot once.			Name and Address of Facility Hysong Co., Inc			
3	Physician (Madical		23a. Part 1. Enter the disease, or comblications hat caused the death. Do not ent shock, or heart failure. List only one aus on each lin- Immediate Cause (Final disease or condition resulting in death)	er the most of dying, such as car fac or	NW , - Was r respiratory arrest,	n.,DC	Approximate Interval Between Inset and Death
	/Medical Examiner	_	Due to (or as a consequence of)				/
8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):				
9	ntificati ng phy s as the		IF FEMALE:				
.O. Box	The law requires that the death certificate has been signed by the attending foage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy]Ectopic pregnancy] Other (specify)		23d. Date of de Month	livery Day Year
<u>α</u>	es pe	þ	Part II. Other significant conditions contributing to death but not resulting in the un	nderlying cause given in Part I.	23e. Did tobacc		o the cause of death?
Vital Records,		Completed	. //		24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of
/ita	i cien : Th certificate ector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death			
ō	ing Physicien: After this certific uneral director,	lon: To	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 1 Natural 5 Pending 1 North, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at 28 Work?	e 5 Residence 8d. Describe how in		cify)
Division of	I or Attend after death Director: , in by the f	Certification;	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No eet, factory, office	Bf. Location (Street City or Town, St	t and Number or Ru tate)	Iral Route Number,
_	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death and or invariant manner stated.	occurred at the time, date and place, ar restigation, in my opinion, death occurred	nd due to the cause d at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Monti	h, Day, Year)
			Chenle W. Karesh W	1 121726	Oc	Pober 1	7,2004
			30. Name and address of person who completed cause of death (Item 23a) (Type, Dr.Charles W. Karesh- 9701-Ver	rs Dr., Rockvil	le,Md.	. , ,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Sta Registra	_	31. Date filed (Month, Day, Year) OCT 2 0 2004 Registrar's Signature	de .			

State of Maryland / Department of Health and Mental Hygien 2 0 0 4 34892 1 - For Stete Registrar Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3 Time of Death **Physician** 4a. Fecility Name (If not institution, give street and number) 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Nursing + Rehab. Center hestertaun 7. Age (In yrs. last birthday) ear 9. Birtholace (State or Foreign Social Security Number 1 M 20 F **Funeral** Days Months Hours Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 √Yes 2 No Director MD Kent Chestertown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21620 USA 112 North Water Street death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. em 27 is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked off jury or other traumatic even George W. Young Kathryn A. Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Young/Brother 112 North Water Street, Chestertown, MD 21620 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: If any injury o Shoops Cemetery OCt.16,2004 Harrisburg, PA 21. Signature of Funeral Service Licenset 22. Name and Address of Facility Fellows, Helfenbein & Newnam, P.A. up. 130 Speer Road, Chestertown, MD 21620 23a. Part1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzheiners **Physician** 6 hears disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that included experts.) Due to for as a consequence of Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. attending physician IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? Month Year 4☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, been signe should be d Completed by HTN 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy has certificate 1∐ Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: Wursing Home 5 Residence 6 Other (Specify) P 1 Yes 20 No 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: After 1 Natural 5 Pending after death.

Director: Aft
d in by the fur investigation 1 □ Yes 2 □No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospitel within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number pleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Da State Registrar

State of Maryland / Department of Health and Mental Hygieney For State Registra 34893 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:40 PM PATEMAN ERIE NOVEMBER 2004 DI /Medical 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner EDEN PINES HAGERSTOWN
If Under 1 Year | If Under 24 Hrs. WASHINGTON 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 223-28-9690 1 M 2 F Yrs. Director VIRGINIA Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. tnside City Limits other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a ITED death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 ☐ Widowed 4 Divorced "netural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) other than 13 <u>ADMINISTRATIVE</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be of Health and Mental Item 27 is marked o FREDERICK" 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHURCH RD Rums 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Department of H Important: If Ite eny injury or ot once. 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from State ANATOMY GIFTS REG. 4 Donation 5 Other (Specify) 21. Signature of European Service Licensee 22. Name and Address of Facility Daugherty Family Funeral Home And Cremation Center, P.A. 2601 Mountain Road - Pasadena, MD, 21122 Part I. Enter the disease, or complications that earlied the death shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and Death To not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition **Physician** ncicona 1 sea resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. tf yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□ Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Cardiongopath Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown peen Dunen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has certificate Arter Dinea 2 -NO 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 45513750 Hospital: ို 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification; 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours aft To the Funeral Di completely filled in 1 Descritiying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) TON THE D18019 NOV 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VASANT 340 MICK ST HAGERSTOWN, MD 21740 DATT MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar NOV 0 4 2004

State of Maryland / Department of Health and Mental Hygiere 0 0 L 34894 1 = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Year OTSE BROWN NOV 2230 /Medical വ 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BALTIMORE der 1 Year If Under 24 Hrs. UNIVERSITY OF MARYLAND MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days 1 M & F Country) West Virginia Yrs. Director 220-14-6535 81 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or iteme 23e or 28e-f show traumatic event. Its Madical Examinar must be notified at 1 Yes 2 □ No Raltimore Director Maryland N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 901 Cherry Hill Road Apt # 255 21225 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, s 1 and 2 should be filad within 72 hours aftar of Haatth and Mantal Hygiana. Item 27 is marked other than "natural", or ital Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Black Spacify: 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Revella Pack Willie Pendleton ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 700 Deacon Hill Ct Baltimore, Maryland 21225 Juanita Brown Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State parmit. Pagas 1 Dapartment of H important: if ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/06/04 Landsdown . Maryland *4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Internal disease or condition resulting in death) blexdim /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, rany, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed attanding physician and for usa as the burial-transit Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | ha 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ paga 2 should ba 2 No 3 Probably Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? 2 🗆 No Division of Vital 1 ☐ Yes 2 No 1 Tyes the Hospital or Attending Physician: Aftar this cartification, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending 4 hours after death. Funaral Director: / death. Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only onel 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AU4176435515240 MP NOV 02, 2004 lauler 30. Name and address of Son who completed cause of death (Item 23a) (Type, Print) Shal S. Greene Baltime MD 2/201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **NOV 0 4 2004** Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 34895 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Robert Ashford Bisselle 2004 November 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 9509 Seddon Road Bethesda Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 ☐ F Months Days Hours Min 578-34-1627 Yrs Director Sept 5, 1927 Washington DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location r than "netural", or items 23a or 28a-f show the Medical Examiner must be rufflied at 10d. Inside City Limits Maryland Montgomery Bethesda Director 1 ☐ Yes 2 🖾 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 9509 Seddon Road 20817 United States Funeral 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Maryes 2 No 1951 — f Yes, Give 1997 — 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: 2 White 3 Widowed 4 Divorced lf Yes, Give Year or Dates: 1987 Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 5+Banker Commercial Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Halbert Thadeus Bisselle ပ္ Alice Ashford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Frances B. Bisselle/wife 9509 Seddon Road Bethesda, Maryland other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Depertment of important: if its any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Nov. 6. 4 ☐ Donation 5 ☐ Other (Specify) 2004 Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home Bethesda Chevy Chase Inc. 7557 Wisconsin Avenue M00092 Bethesda, Maryland 20814 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Respiratory Arrest Examiner Due to (or as a consequence of): Physician/Medical Examiner Multiple Myeloma The law requires that the death certificate be executed attending physician end for use as the buriei-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ul): Box 68760, Due to (or as a consequence of): P.O. After this certificate has been signed by the signeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Š Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2X No 1 ☐ Yes 1 ☐ Yes 2 ☐ No erai Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 512 Residence 6 Other (Specify) r 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Tyes 2 TNo 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) or A efter 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D43130 November 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

510 Idlewild Avenue, Easton, Maryland 21601

DHMH 16 Rev 6/95

State Registrar Mary B. Burgoyne, M.D.

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			For State Registrar	State of Ma	il ylariu / L	Cer	tificate of	Death		19. No.	UL	34896
			Decedent's Name (First, Middle, La	st)					2. Date of Deat	1	Vana	3. Time of Death
н	Physici /Medic		Margaret	B. Bake	er				November	2, 20	004	12:30 p ^M
	Examin		4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Deat	h	4c. Count	y of Death	
п			46 E. Chatswort	h Avenue				erstown			timor	
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birt		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year)	9. Birthp	place (State or Foreign ntry)
	Director		216-28-6753	- Lander	74	Yrs.			June 6,	1930	Mary	land
	and and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Lo	cation				1	IOd. Inside City Limits
	Aaryl f sho	ō	Maryland Baltimo			D.c	istersto	t.m			İ	1 ☐ Yes 2 🛣 No
	the t	Director	10e. Street and Number)Te		100	10f. Zip Code	WII	10	g. Citizen of	What Cour	ntry?
	3a or	0	46 E. Chatswor	rth Avenue			21136			IJ.	S.A.	
	death me 2:	Funerai	11. Marital Status	12. Was Decedent B	ver in U.S.	13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Ra	ce - Americ	
ယ	or Ite	Fur	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 XN If Yes, Give	lo	1	r Yes, specify Cuba I ☐ Yes 2 🔯 No		to Hican, etc.)		ick, White,	etc.
8	rel', c	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:			163 224110	Specify.		Specil	Whi	ite
2	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "neturel", or iteme 23a or 28a-f show event. If a Madical Exercities is and event.	Completed by	15. Decedent's E (Specify only highest gra		16a.	Deced (Give	lent's Usual Occup kind of work done o OO NOT use retired	ation during most of wo	rking	6b. Kind of B	Business/In	dustry
2	vithin ne. han	m jd	Elementary/Secondary (0-12)	College (1-4or 5	+)		oo nor use retired sewife	1)		Oran	ı Home	
'n	led v tygie her t		12 17. Father's Name (First, Middle, Last	1	n	ious	sewile	18 Mother's Na	me (First, Middle, M			<u> </u>
anc	ntal Hed of	Be	Rob Roy Burge						Ruth	Kin	•	
Ž	hould d Me mark matic	ဥ	19a. Informant's Name/Relationship (19h	Mailin	a Address (Street :		ural Route Number,			Code)
Maryland 21215-0036	d 2 s th an t7 is trau		Harry A. Baker	Husband			•		e Reister	-		21136
ē	1 an Heal tem 2		20a. Method of Disposition	<u> </u>	20b. Place of	Dispo	sition (Name of			Oc. Location		
2	ages ant of it: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special				natory or other place.dge Cem.		6-04 P	ikesvi	11e.	Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Iteme 23a or 28a-f show any injury or other traumatic event. The Marical Extractive from the Indiffed of Once.		21. Signature of Funeral Service Lice						824 Reist			
ď	Departing Department of the poores.		Frank S	lini		EL	INE FUNE	RAL HOME	Keisters	town,	MD 21	136
	10 10 10 10	<	23a. art1. Enter the disease, or com- hock, or heart failure. List only	plications that caused one cause on each lin	the death. Do r	not ente	er the mode of dyin	g, such as cardia	c or respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	META	TATIC	7/	BREA		A			Onset and Death
	/Medical	H	resulting in death)	Due to (or as a	a consequence of	of):						1 4
В	Examiner		Sequentially list conditions.	b								
	be is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events	Due to (or as a	a consequence of	of);						
/	tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence (of):					-	
68760,	be ey ician buria											
387	icate phys s the	edical		_ d								
	certii nding use a	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d. Da	te of delive	эгу
Вох	death cer e attendir d for use	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregnancy Other <i>(specify)</i>			Mo	onth	Day Year
ó	The law requires that the death cer tie has been signed by the attendin bage 2 should be detached for use	Physician/N	9 🗆 Unknown	9□ Unknown								
o,	w requires that s been signed t should be det	by P	Part II. Other significant conditions	contributing to death bu	it not resulting in	n the ur	iderlying cause give	en in Part I.				ne cause of death?
ğ	en sig								1 Te	s 2 □ No	3 Prob	ably 4 Hhknown
Records,	has be	ple							24a. Was an		prior to cor	psy findings available mpletion of cause of
		Completed							perform	ed?	death?	2[] No
Vital	Physician: Th this certificate ral director, pag	Be (25. Was case referred to medical examiner?						ath (Check only one)		
of \	d is	은	1 Yes 2 No	Hospital:				4 Nursing F	lome 5 Hesider		, , ,	y)
n C	tending Ph leath. tor: After th the funeral	ion:	27. Man of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day		rime of nju ry	28c. Injun Worl	yat k? Yes 2 □ No	28d. Describe how	w injury occur	red	
isi		icat	2 Accident investigation 3 Suicide 6 Could not be	e 200 Plana of Inju	ırv - At home, fai	rm stre		193 2 110	28f. Location (Str	eet and Numb	ber or Rura	l Route Number.
Division	or Dir	Certification:	4 Homicide determined	building, etc	. (Specify)	, 511	ot, lastory, since		City or Town,			,
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	aic		nysician: To the best of								
	n 24 to 70 To Fu	ledical	(Check only 2 Medical Examone)	niner: On the basis of and manner sta		d/or inv	restigation, in my o	pinion, death occu	irred at the time, da	te and place,	and due to	the cause(s)
	To the within To the comp	M	29b. Signature and title of certifier	/ -A-	^		29c. License		29	d. Date signe		/
	1		Houwork	mel	MD		D39	5398		11 -	5-6	ンナ
	h		30. Name an address of person who	completed cause of de	eath (Item 23a) ((Туре,	Print)	who it	C, HD 211	157	of S'est, or other	
_			FlAvio Noute MI) DD Dal	de Cionetura			LYMIWA	0,510 211			
	Sta Registr		31. Date filed (Month, Day, Year)	04 January	irs Signature	L	and I					
	2000	100		1-3-00-01	- 20	199	-					

Amend item #281, perfit, G837, 1174/04, 11 State of Maryland / Department of Health and Mental Hygiene 2001,

34897 For Stata Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Year DAVID BISSELL OCTOBER 2004 /Medical 12:03 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death LAUREL REGIONAL HOSPITAL
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) LAUREL PRINCE GEORGES If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) **½** M 2□ F Months Days Yrs Director 62 216-82-9406 NEW YORK DEC. 12 1941 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be rigitied at 1 QYes 2 ☐ No Direct PRINCE GEORGES BELTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 20705 Funeral 4217 BRANDON 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2∑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 ◯XNo WHITE If Yes, Give Year or Dates: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) N/A UNEMPLOYED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit iment of Health and Mental H tant: If item 27 is marked ot Be JOSEPH BISSELL CATHERINE SAINT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SOCIAL /WORKER 1401 MCCORMICK DR. JACQUELINE ANDERSON LARGO, MD 20774 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date Department of H Important: If itel any injury or ott 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State BALT. WASH.CREMATORY 11/1/04 LAUREL, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility FLECK FUNERAL HOME INC. 21. Sign ture I Funeral Service Licenses 7601 SANDY SPRING RD LAUREL, MD 20707 23a. Part1, Enter the disease shock, or heart failure. sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** COMPLICATIONS OF FEMUR FRACTURE FROM ACCIDENT DAYS resulting in death) /Medical Due to (or as a consequence of): Examiner Kid Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Examine physicien and s the burial-transit Die Due to (or as a consequence of): Physician/Medicai attending f IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۵ certificete has been si rector, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Date of Injury 28b. Time of 28d. Describe how injury occurred Fell having a Secrete Certification; 1 Natural 5 Pending Runay death. .00 М 1 ☐ Yes 2-7No after death

Director: A 2 Accident
3 Suicide investigation 7 Pace of Injury - 1 hom building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) 4217 Brandow Lane Betsvelle june 1450 home, farm, street, factory, office filled in by 4 - Homicide To the Hospital within 24 hours at To the Funeral D completely filled in 157 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Vio D29923 OCTOBER 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARIE A. DOBYNS, M.D. . 7350 VAN DUSEN #320 LAUREL, ND 20707 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 4 2004 Registrar

ORIGINAL

			For Amend Item 17	gate of Many bang	l_⊈epa Cei	urtment o	of Health a of Death	and Mental H	ygiene 0	04	3489	8
ľ	Physici		Decedent's Name (First, Middle, Last) ROS	· · · · · · · · · · · · · · · · · · ·	-	BODENH	HEIMER	2. Date of D Month NOVEME		004°	3. Time of Dea 7:45	ith AM
7	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, Tow	vn, or Location of	of Death		y of Death		
			7218 PARK HEIGHTS		- 4 F- 2 - 4 - 1	If I lader 1 V		IMORE			N/A	
	Funeral Director		5. Social Security Number 214-36-9819 6. Sex 1 □ N	7. Age (In yrs. la)4 Yrs.	Months Da	ays Hours	Min. B. Date of B	1900	9. Birthp	place (State or For	Υ
			Usual Residence of Decedent									
	show	7	10a. State 10b. County		Town or Lo					'	0d. Inside City Lir 1 ☐ Yes 2 🔯	
	28a-f	recto	MD BAL 10e. Street and Number	TIMORE	SIEVI	ENSON 10f. Zip Coo	de		10g. Citizen of	What Cour		
	3a or	io le	2100 WILTONWOOD ROA	ND			21153	3			sÁ	
	ems 2	Funeral Director	11. Marital Status	Was Decedent Ever in U.S Armed Forces?	i. 13. \	Was Decedent f Yes, specify (of Hispanic Ori Cuban, Mexican	igin? (Specify Yes or N n, Puerto Rican, etc.)	o- 14. Rac Bfa	ce - Americ		
30	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🌠 No ff Yes, Give Year or Dates:		1□ Yes 2🂢			Specif		WHITE	
5-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "natural", or Items 23a or 28a-f show uthar than "natural", or Items 12a or 28a-f show ant, the Medical Examinat must be rediffed at	ted t	15. Decedent's Educat	ion		ient's Usual O		A of modeloo	16b. Kind of B	lusiness/In	dustry	
2	ithin 7 le. lan "n	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use re			BALTO I	HEDDE	LI HNTV	
7	fited withi Hygiene. othar than	Cor	17. Father's Name (First, Middle, Last)		KESE	AKCH LI	BRARIAN	er's Name (First, Middle	1		M ONIV.	
Maryland	be de la la la la la la la la la la la la la	To Be	JOEF Josef Bende	r	BEND	FR-		ENNY	0, 1114/0017 0017/47	,,,,	STERN	
ary	should and Men s marka umatic	-	19a. Informant's Name/Relationship (Type					er or Rural Route Num	ber, City or Town	, State, Zip		
	s 1 and 2 should Health and Mer itam 27 Is marks other traumatic		BERTOLD BODENHEIM					DAD - STEVE				
altimore,	00-		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem	oval from State cei	metery, cren	sition (Name on atory or other	place)	Date	20c. Location			
	E 8 .2		 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 	CHEV		AVAS CH		11/03/2004 ™ SOL LEVIN	1		OWN, MD	
n	permit Depart Import any in		1 Mans					OWN ROAD -				<u>,</u>
			23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the death.	A				arrest,		Approximate Interval Between	
í	Physician	18	Immediate Cause (Final disease or condition resulting in death)		AL	246	IMER	S			Onset and Death	1
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):							
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09/89	ate hy:	edical	d									
XOX	eath certific attending p for use as f	Physician/Me	23b. was decedent pregnant	If yes, outcome of pregnan		Ectopic pregna	ancy			ate of delive	•	
o n	e deat the att	slcia	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea 9☐ Unknown		Other (specif)			Mo	onth	Day Year	
7.	res that the de signed by the a be detached f		Part II. Other significant conditions contri	outing to death but not resul	ting in the ur	nderlying cause	e given in Part I.	. 23e. Did	tobacco use con	tribute to th	e cause of death	? _
ecords,	uires n sign	d by						1 🗆	Yes 2□No	3 🗌 Prob	ably 4 Donkno	own
O O O	aw require s been si 2 should b	plete						24a. Wa	s an 24b.	Were auto	psy findings availa	able
Ĭ	(G)	Completed						auto perf 1 ☐ Yes	ormed?	death?	2 No	OI
Vital H	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	pital:			Othor	of Death (Check only				_
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0	Attending I death. ctor: After y the funer	atior	Natural 5 Pending investigation	(Month, Day Year)	Injury		Work? 1 ☐ Yes 2 ☐ I	No				
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, str	eet, factory, off	fice		(Street and Numb own, State)	oer or Rura	l Route Number,	
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	the Ho in 24 the Fu ipletel	ledical	one)	On the basis of examination and manner stated.	on and/or inv			th occurred at the time				
	with To	Σ	29b. Signature and title of certifier	004 00	ia a	29c. Lic	cense number	20-	29d. Date signe	d (Month, l	D ay , Year)	
/			30 Name and address of person who com	pleted cause of death (Item)	23a) (Tyna	ツ Print)	000	3	"///	04		
0	1		TASNEEM C	AKHANI,	72 2	O PA	ARK F	TEIGHTS	ANE	13A	un Mi)
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C	Registr		NOV 0 4 2004	Streva	19	Spark	2					
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			1 - For State Registrar	State of Maryla		artment of tificate of		d Mental Hygie		34899
	Physici	ian	1. Decedent's Name (First, Modie, Last)	O R		4		2. Date of Death Month	Day Year	3. Time of Death
	/Medi	cal	Dorolnea		enne			October	27, 2004	11:00 AM
1	Examir	ner	4a. Facility Name (If not institution, give sp	get and number)		46. City, 16Wh	or Location of D	t mo	4c. County of Dea	th
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs	. last birthday)	If Under 1 Yea		Hrs. 8. Date of Birth	9. Bir	thplace (State or Foreign
	Director	•	262-29-2011	N 2 3 - 8	7 Yrs.	Months Day	s Hours M	in. 8. Date of Birth (Month, Day, Y	1917 Flo	orida
	and w		Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Lo	nation				
	Manyta f sho	ō	MD Howard	100.0	Ellicot					10d. Inside City Limits 1 ☐ Yes 2√∑ No
	the 28a-	Director	10e. Street and Number		Dirico	10f. Zip Code		10a	. Citizen of What Co	
	h with		3004 North Ridge F	load			21043		USA	
	deat	Funeral		. Was Decedent Ever in t Armed Forces?	J.S. 13. V			(Specify Yes or No- lerto Rican, etc.)	14. Race - Ame	
98	or It.	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		☐ Yes 2 N		eno nican, etc.)	Black, Whit	
Ś	hours tural'	ed by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:					Specify: Wh	
21215-0036	d within 72 hours after death with the Maryland jiene. r than "natural", or Itams 23a or 28a-1 show the Medical Evarif et must be positied at	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	(Give I	ent's Usual Occi kind of work don OO NOT use retir	e during most of	working 161	b. Kind of Business	Industry
212	77 75 10 100	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		housewi	Lfe		own home	49
b	Hyger Hyger	Bec	17. Father's Name (First, Middle, Last)			11000000		Name (First, Middle, Mai		
<u> </u>	should be and Mental markad c	To	Gurth Comerford	Clarkson			Leon	na Aline Sm	ith	
Maryland	and s m		19a. Informant's Name/Relationship (Type	·	19b. Mailin	g Address (Stree	et and Number or	Rural Route Number, C	ity or Town, State, 2	Zip Code)
	of Health itam 27 I		Mary B. Volland/dau 20a. Method of Disposition		9621 S Place of Dispos	Susies W	ay Elli	Date City, N		-
Baltimore,	S		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ren		cemetery, crem	atory or other pl	ace)	Da(9 200	c. Location - City or	Town, State
			* 4 ☑ Donation 5 ☐ Other (Specify)	2/	22	Name and Add	ress of Facility			
a	permit. Departr Imports any inje		21 Sig the of Funeral Sinvice Licensee	Directo	r S	tate Ana	atomy Bo	ard 655 W.	Baltimore	Street
			23a. Part1. Enter the disease or complica shock, or heart failure. List only one	tions that caused the dea	th, Do not ente	r the mode of dy	e, MD 2 ring, such as card	1201 iac or respiratory arrest,		Approximate /
	Physician		Immediate Cause (Final disease or condition	Henate	ater	Care	MEN			Interval Between Onset and That
	/Medical Examiner		resulting in death)	Due to er as a consec	quence of):		010011			110.11
	LAUIIIIICI	<u>د</u>	Sequentially list conditions, b if any leading to immediate	Due to for as a conse	tuones off:					
	nsit	Examiner	Cause (Disease or injury	Due to for as a consec	menca crij:					
Ć,	execu in and ial-tra	Еха	that initiated events c. resulting in death) Last	Due to (or as a consec	(uence of);					
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	dlcal	d.							
9	artifica ing ph e as th	Med	IF FEMALE:		-					
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnation 1 Live birth 2 ☐ Feta	ıl death 3 □l	Ectopic pregnanc	су		23d. Date of deli	,
	the de y the a iched f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of o	leath 5	Other (specify) _			Month	Day Year
۵.	that ed b deta	/ Ph	Part II. Other significant conditions contri	buting to death but not res	sulting in the unc	derlying cause gr	ven in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
Records,	quires n sign	d by	HIN					1 ☐ Yes		obably 4 Unknown
000	s been si	olete	Grenua					24a. Was an	24b. Were au	topsy findings available
æ	The law requires ate has been sign page 2 should be	Completed	NEDDIM					autopsy performed	? prior to c death?	ompletion of cause of
		Bec	25. Was case referred to medical				26. Place of D	1 ☐ Yes 2 ☑ eath (Check only one)	No 1 ☐ Yes	2 No
of <	tending Physicien: leath. tor: After this certific the funeral director.	To	1 165 2		ER/Outpatient	3□ DOA Ot	L	Home 5 Residence	6 Other (Spec	
		lon:		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. inju Wo		28d. Describe how in	ijury occurred	LIVING
Division	l or Attendi after death. Director: A lin by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ama farm stee		Yes 2 No	OOK I applies (Otsert		12
<u>≤</u>	after Direct Jin by	ertii	4 Homicide determined	building, etc. (Specif	y)	et, ractory, office		28f. Location (Street City or Town, St	and Number or Hui ate)	rai Houte Number,
	pspite hours inaral y filled		29a Certifier 1 Certifying Physic	an: To the best of my kno	wledge, death	occurred at the ti	ime, date and pla	ce, and due to the cause	(s) and manner as	stated.
	To tha Hospitel or Attending within 24 hours after death. To tha Funaral Director: After completely filled in by the funa.	edical	(Check only 2 Medical Exeminer one)	On the basis of examina and manner stated.	tion and/or inve	estigation, in my	opinion, death oc	curred at the time, date a	and place, and due	to the cause(s)
	Vith To t	Σ	29b. Signature and tipe of certifier	1 #	4	29c. Licen	se number	29d. I	Date signed (Month	Day, Year)
			Dugan (1)	ignil	MA) /	005 8	622	10/2	0104
	Parameter and the second		30. Name and address of person who com	neted cause of death (Item	23a) (Type, P	rint) - 3	/2	Patto n	nd n	1209
	Sta	te	31. Daty filed (Month, Day, Year)	32. R gistrar's Signa	iturg	h /		mike,	1002	1201
	Registra		MON 0 4 2004	Sereva	00	Spork	21			

			For Stata Registrar	State of Maryland		artment of rtificate of				Reg. No2	104	34900
	Physici		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al -	DONALD RICHAR			4b. City. Town	or Location		Ictobe		2004 ity of Death	8:05 am
	Examin	er	4a. Facility Name (If not institution, give str	1		G		0.1			N/A	
	Funcional		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Yea	r If Under	(1 Hrs.)	8. Date of Birt	h	9. Birth	place (State or Foreign
	Funeral Director		155-30-3938 Usual Residence of Decedent	M 2□F 63	Yrs.	Months Day	's Hours	Min.	(Month, Da JUL 28			RYLAND
	land w		10a. State 10b. County	10c. City	, Town or Lo	ocation						10d. Inside City Limits
	Many First	ţ	MARYLAND N/A		BALTIN	IORE						1X□Yes 2□No
	th the	Director	10e. Street and Number			10f. Zip Code	9			10g. Citizen o	of What Cou	intry?
	23a c		2734 LONGWOOD St.				1216			U.S.		
36	within 72 hours after death with the Maryland iene. rthan "netural", or Items 23a or 28e-f show the Medical Examinar must be multified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 XX Sec. 2 ☐ No If Yes, Give Year or Dates:	1	Was Decedent of If Yes, specify Cu			cify Yes or No Rican, etc.)	В	ace - Amer lack, White cify: BLA	
우	thou stura		15. Decedent's Educa		16a. Dece	dent's Usual Occ	upation	-1 -1 - 10	_	16b. Kind of		
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212		E	12th grade	4 yrs	SUPER	RVISON/M						PARKS
ם	be filed tal Hygi d other event, I	Be (17. Father's Name (First, Middle, Last)				18. Moth	ner's Name	(First, Middle,	Maiden Sum	ame)	
yla	D & 3 C	ု	RICHARD COOPER						WADE			
Maryland	C1 00 = 82		19a. Informant's Name/Relationship (Type	e, Print)	1	ng Address (Stre						
	s 1 and 2 f Health item 27 I	1 3	<u>Iris Cooper/Wife</u> 20a. Method of Disposition	20b. P		25 Gwyns osition (Name of	Falls		, Balt	1more, 20c. Location		land 21216 fown, State
Ö			1 ☐ Burial 2XX remation 3 ☐ Re	moval from State	emetery, cre	matory or other p	1		1			
Baltimore,	t. Pa rtmen rtent;		*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral/Service Licenset			REMATORY 2. Name and Add		11-04	-04	BALTIM	ORE, I	MARYLAND
Bal	permit. Page Department of Importent; if any injury or once.		Martina C	1	W	LLIAM C	BROWN	1 COMM	YTINU	FUNERA	L HOM	E P.A.
			23a Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the death cause on each line.	n. Do not en	ter the mode of d	tying, such a	s cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
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н	/Medical Examiner		resulting in death)	Due to (or as a consequent	uence of):							
н	LAdillilei		Sequentially list conditions, b.	Due to (or as a consequ	uence of):							
	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to tor as a consequ	derice or).							
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687		adic	0.									
Вох	leath certifical attending phy ifor use as th	Physician/Med	1F FEMALE: 23b. Was decedent pregnant 23	c. If yes, outcome of pregna		75				23d. [Date of delin	/ery
Ď.	death e atte d for	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d		⊒Ectopic pregna: ⊒ Other <i>(specify)</i>				1	Month	Day Year
P.0	that the de ed by the detached	hys	9 Unknown	9□ Unknown								
Ś	Se Co	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the I	underlying cause	given in Part	· I.		obacco use co Yes 2 □ No		the cause of death?
Record	s been si	ojet	_						24a. Was		b. Were aut	opsy findings available ompletion of cause of
Re	The lav	Completed							perfo	2 No	death?	
Vital	ien: rtifica stor. p	BeC	25. Was case referred to medical				26. Plac	ce of Death	(Check only o	one)		
f V	Physicien: r this certificated rail director.	10	examiner? 1 ☐ Yes 2 ☑ No	spital: 1 Inpatient 2	ER/Outpatie	nt 3L DOA	Other: 4 N	Nursing Hor	ne 5□Resi	dence 6 🗆 C	ther (Spec	ify)
on of	ing Pt I. After th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	V	njury at Work? □ Yes 2 [28d. Describe	how injury occ	urred	
Division	Attending or death. ector: Atterby the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, si				28f. Location (: City or To	Street and Nui wn, State)	mber or Ru	ral Route Number,
Ö	urs afte			, it		**************************************	- time date s	and place of	and due to the	course(s) and	mannar ac	ctated
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical		ician: To the best of my kno er: On the basis of examina and manner stated.								
	To the within 2 To the complet	ž	29b. Signature and title of certifier	4-0			ense number	2		29d. Date sig		
•		-	flangant	mo .		89	1520	1		10	-31-	70
	7		30. Name and address of person who cor	mpleted cause of death (Item	n 23a) (Type	· · ·	and C	TONDO	al Ho	so: ta	1	-
		ate	31. Date filed (Mppth, Pay, Year)	32. Registrar's Signa	ature /	Marylo	uvic	MICI	VI CIO	spila	l	
	Regist		NJV 0 4 2004	Spera	19	400xx	2					

Physic	ian	1. Decedent's Name (First, Middle, Last)	ertificate of Death 1/08/04 JH	Reg. No. 2. Date of Death Month Day 2. 2004 3. Time of Death Annual Day 2. 2004	of Death
/Medi Exami	cal	LESLIE H. CHAMP 4a. Facility Name (If not institution, give street and number) MARYLAND GENERAL HOSPITAL	4b. City, Town, or Location of Death BALTIMORE	4c. County of Death	
Funeral Director		5. Social Security Number 226 38 8880 Usual Residence of Decedent 6. Sex 7. Age (in yrs. last birthda) 71 Yrs.	/ If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, Year) 4ARCH 25, 1933 VIRGINIA	or Foreign
e Maryland 8e-f ehow niified et	ctor	10a. State 10b. County 10c. City, Town or I MD N/A BALTIMORI	Σ		City Limits
with th	Dire	10e. Street and Number 1100 PENNSLYVANIA AVE APT 401	10f. Zip Code 21201	10g. Citizen of What Country? U.S.A	
d within 72 hours after death with the Maryland siene. Then "neturel", or Items 23e or 28e-f show the Madicial Erain, or Inust be notified at	by Funeral Director		. Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F		
within 72 hou ene. then "neture he Medical E	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of workin DO NOT use retired)		
be filed ital Hyg id othe event,	Be	2 YEARS RETTI 17. Father's Name (First, Middle, Last) UNKNOWN	RED VETERAN 18. Mother's Name EDNA	(First, Middle, Maiden Sumame)	-
2 shot and N is ma	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mai		Route Number, City or Town, State, Zip Code)	
용 := = =		1 Burial 2 Gremation 3 Hemoval from State 4 Donation 5 Other (Specify) GREEN MOI	ematory or other place) UNT CREMATORY NOVEM	o5 BER 5, 2004 BALTO, MARYI VIN B. SCRUGGS FUNERAL B	AND
permit. Pag Department Importent: eny injury o		Deinadene Varienes 1	412 E. PRESTON STRE	ET BALTIMORE, MARYLAND 2	21213
Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	oma of bladder	respiratory arrest, Approxima Interval Be Onset and	tween
re be executed ysician and e burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c			
The law requires that the death certificate East been signed by the attending physic page 2 should be detached for use as the b	Physiclan/Medl		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day	Year
quires that n signed b uld be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the Renal Failure	underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐	
	Completed	Urinary tract infection		24a. Was an autopsy performed? 1 \(\superscript{Yes} \) 2 \(\superscript{\subsets} \) No \(\superscript{1} \superscript{Yes} \) 2 \(\superscript{No} \)	available cause of
The law requisate has been page 2 should		25. Was case referred to medical examiner?	26. Place of Death	(Check only one) e 5 ☐ Residence 6 ☐ Other (Specify)	
Physicien: this certificated ral director, I	To Be	1 ☐ Yes 2 🛣 No ☐ Hospital: 1 ☐ Inpatient 2 🛣 ER/Outpati 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	of 28c. Injury at 2	8d. Describe how injury occurred	
or Attending Physicien: after death. Director: After this certifics in by the funeral director, I	To Be	1 ☐ Yes 2 🛣 No	of 28c. Injury at Work? M 1 Yes 2 Ki No	Bd. Describe how injury occurred Control (Street and Number or Rural Route Number or Town, State)	nber,
or Attending Physicien: after death. Director: After this certifics in by the funeral director, I	Certification: To Be	1 Yes 2 No Hospital: 1 Inpatient 2 EVOutpati 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, shullding, etc. (Specify) 29a. Certifler (Check only 2 Medical Examiner: On the basis of examination and/or	of 28c. Injury at Work? M 1 Yes 2 1 No street, factory, office 2 ath occurred at the time, date and place, a investigation, in my opinion, death occurre	8f. Location (Street and Number or Rural Route Nur. City or Town, State) nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(
Physicien: this certificated ral director, I	To Be	1 Yes 2 No Hospital: 1 Inpatient 2 EVOutpati 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time (Month, Day Year) 28b. Place of Injury - At home, farm, shullding, etc. (Specify) 29a. Certifler (Check only 2 Medical Examiner: On the basis of examination and/or	of 28c. Injury at Work? M 1 Yes 2 No street, factory, office 2 ath occurred at the time, date and place, a	8f. Location (Street and Number or Rural Route Nur. City or Town, State) nd due to the cause(s) and manner as stated. d at the time, date and place, and due to the cause(

State of Maryland / Department of Health and Mental Hygien 00 L 34902 ITEM #20b PER FH G837 19 POS 1894 e of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician DENNIS CORNISH NOVEMBER 2, 2004 8:36P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner BALTIMORE
Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Days Hours Min. APRIL 1, 1951 N/A 501 E.PRESTON STREET 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 🛣 M 2 🗆 F MARYLAND 219 56 3937 53 Yrs Director Usual Residence of Decedent 10c, City, Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Madical Examiner must be notitled at 1X Yes 2 No Director MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 501 E. PRESTON STREET APT 611 21202 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "rangi njury or other traumatic event, Ita M. ang none. 1 Flementary/Secondary (0-12) College (1-4or 5+) COKE OVEN WORKER BETHLEHEM STEEL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) EDWARD A. CORNISH LAURA E. MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MELITA PORTER (DAUGHTER) 401 S. BENTALOU STREET BALTIMORE, MARYLAND 21223 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State Db. Place of Disposition (wante of Capacity Company) of the Capacity of Capacity Office (Capacity Capa * 4 ☐ onation 5 ☐ Other (Specify) 2004 BALTO, MARYLAND 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME nature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1412 E. PRESTON STREET BALTIMORE, MARYLAND 21213 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 061 disease or condition resulting in death) /Medical (or as a consequence of): Examiner 9 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine use as the burial-transit certificate be executed that initiated events attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ eq 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death?

1 → Yes 2 □ No 24a Wasan autopsy 1 X Yes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6X Other (Specify SCENE 1 X Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After **⊠**Naturai 5 Pending after death. 1 TYes 2 No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cai сопрівівіч Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only onel 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title O.C.M.E. NOVEMBER 3,2004 who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) State 0 4 2004 Registrar

32. Registrar's Signature

111 Penn Street, Baltimore, Maryland 21201

State of Maryland / Department of Health and Mental Hygien 20 0 [4 34903 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** Carmichae1 November 1, 2004 Martha Ann 6:21 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel ff Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
January 30, 1949

9. Birthplace (State or Fo. Country)
Rhode Island Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🂢 F 55 Director 496-56-4936 Usual Residence of Decedent with the Maryland 10d. fnside City Limits 10a. State 10b. County 10c. City. Town or Location r than "naturel", or iteme 23a or 28a-f ehow the Medical Examiner roust be notified at 1 X Yes 2 ☐ No Directo Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 United States 253 Tilden Way death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 X Married 10 1 ☐ Yes 2 No If Yes, Give Year or Dates Specify: Specify: White <u>م</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) Colfege (1-4 or 5+) Administrative Assistant Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ould be f Adalene Peeler John Parks Morris treumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 Iment of Health a tant: If item 27 Ir Charles L. Carmichael/Husband 253 Tilden Way, Edgewater, Maryland 21037 other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition November 3, 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. injury or Montgomery Crematorium, Inc. 2004 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda—Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814—3501 21. Signature of Funeral Service Licensee M00198 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Shock **Physician** /Medical Due to (or as a consequence of) Examiner lostoidin Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No jo 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 No Completed Breast Cancer 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy performed? 1 ☐ Yes certificate Physicien: director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification; To 1 Yes this After the funeral 27. Manns of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred aturaf Attending 5 Pending To the hospers within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determin 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DCCC058297 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Conter Anne Arrandel MD Z1401 MO

Registrar DHMH 17 Rev 1/2001

State

it. Youws 31. Date filed (Month, Day, Year)

NOV 0 4 2004

Baltimore, Maryland 21215-0036

P.O. Box 68760

of Vital Records,

ORIGINAL

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien 00 L 34904 For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Charles Willard Clark October 0 29, 2004 2255 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Cumberland A<u>llegany</u> If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□ F 215-42-4411 62 Director 7, 1942 Maryland Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at MD Allegany Westernport 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25701 Shady Lane SW 21562 Funeral **IISA** filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates: 162-64 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, unk Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) salesperson dept stores 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is markad oth any injury or other traumatic avent 2008. Be James Edward Clark Beulah Kathleen Crowe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earl Clark/brother 2702 George Washington Hgwy Oakland, MD 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Euneral Service Ucensee Ronald S. Wade man 23a. Part1. Inter the disease, or complications that caus shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, line. Approximate Interval Between Onset and Death Immediate Cause (Final COPD (chronic obstructive lung disease comonths End stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed burial-transit that initiated events signed by the attending physicien and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should I 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2X No certificate has page 2 1 Tes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2XNo completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Doc 55325 Worsocket 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frostburg MD 2153 48 Tarn WONSOCK SHIN Terrace 31. Date filed (Month, Day, Year) 32. Registrar's Signature State WOV 0 4 2004

DHMH 17 Rev 1/2001

Registrar

			For State Registrar			of Mai	ryland /	Depa Cer	rtmen <i>tificat</i>	t of H e of L	ealth a	and M		Heg. No	200	l.	349	05
	Physici	an	1. Decedent's Name		*								2. Date of De Month	ath Da	y \	/eer	3. Time of	
	/Medio	cal	Francois 4a. Facility Name (/	M. Doste		umbar)			4h Cih.	Town or	Location of		October				3:50	РМ
	Examir	ıęr		ramount I		iuiiio o i)				cvil]) Death			. County of			
	Funeral		5. Social Security N	umber 6.8	өх	7. Age	(In yrs. last i	birthday)	If Under	1 Year	If Under		8. Date of Bir	th	ontgo	9. Birthp	lace (State o	or Foreign
	Director		457-60-2	536	⊠ M 2□F		65	Yrs.	Months	Days	Hours	Min.	(Month, Da 09/09/	1939		Coun Nash	ingtor	n, DC
	and		Usual Residence of 10a. State	Decedent 10b. County			10c. City, To	own or Lo	cation							1	0d. Inside Ci	ity Limits
	Maryl f sho	jo	MD	Montgome	rv		Germa	ntow	m								1 🗀 Yes	
	r 28e	Director	10e. Street and Nur				- OCTING	iii LOW	10f. Zip	Code				10g. Cit	izen of Wh	at Coun	try?	-
	death with the Maryland ms 23a or 28e-1 show rms1 be notified at	al D	13069 Ор	en Hearth	Way				208	374				U.S	S.A.			
30	within 72 hours after death with the Marylan liene. r then "natural", or itams 23a or 28e-1 show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Marri 3 Widowed	ied 2 Married	1 _Yes	Forces? s 2 X No Give		11	Vas Deced Yes, spec	ify Cuba	spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	-	14. Race Black,	White,	etc.	
315-003b	hour		3 🗀 44100M90	15. Decedent's E	Year or	Dates:	16	Sa. Deced	ent's Usua	I Occupa	ntion			16b K	ind of Busi			
2 5	nin 72 in nation	Completed	(Spec	ify only highest gra	de complete	d) (1-4or 5+)		(Give	kind of wor OO NOT us	rk done a	urina mosi	of worki	ng					
7	filed within Hygiene. Ither then ant, the Me	Com	11	(10ary (0 12)		(1-401 54)	′ <u>T</u>	axi	Cab D	rive	er			116	nspoi	Lat		
ם	9 E 5 S	Be	17. Father's Name										(First, Middle,	Maiden	Sumame)			
Maryland		To	Leon E. I		Time (Dried)			Ob 14-10-		(0)			Baker					
Z	d 2 sl th an 27 ia r treur		Nancy A.	ame/Relationship (Park Ni									Couman	-				7/
<u>ق</u>	ss 1 and 2 should of Health and Mer itam 27 is marke r other treumatic		20a. Method of Disj	position			20b. Place	of Dispos	sition (Nan	ne of			German		Man cation - C			3/4
E	Pages nent of I int: If it		1 ☐ Burial 2] 1 ☐ Donation	Cremation 3 5 Other (Specif]Removal from	n State			-	,		10/31	/2004	Bre	ntwoo	nd. I	Maryla	nd
baitimore,	permit. Pages Department of I Importent: If its any injury or of		21. Signaldre of Fu	Mm Jun	1 - M	all	1	22.	. Name an	d Addres	s of Facilit	y g	Simple Rockv	Trib	ute			
			23a. Part1. Enter the	ne disease, or com rt failure. List only	plications that	t caused	death. D								, iidi	. 7 1 4.	Approximate Interval Bet	9
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DIVISION	a Hospital or Attandin n 24 hours after death. te Funaral Diractor: Att bletely filled in by the fun	Certification:	3 Suicide 4 Homicide	6 Could not b determined	289. Plat	ce of Injury ding, etc.	y - At home, (Specify)	farm, stre	et, factory	office		2	8f. Location (5 City or Tox	Street and In, State	d Number)	or Rural	Route Numb	ber,
	To the Hospit within 24 hour To the Funers completely fille	edical	29a. Certifier (Check enly one)	1☐ Certifying Ph 2X Medicel Exer	niner: On the	he best of basis of e	xamination a	ge, death and/or inv	occurred a estigation,	at the time in my op	e, date and inion, deat	place, a	nd due to the old at the time,	cause(s) date and	and mann place, and	er as sta due to	ted. the cause(s)	
	To t To t	Σ	29b. Signatule and	title of certifier	(0	أسيدا			29c.	License				1	e signed (/		ey, Year)	
			, ~		rms (C	ME)				O12	436			10/	29/04	1		
			30. Name and addr															
	Sta	to.	Carl Moan 31. Date filed (Mon		D, 111.	25 Ro Registrar'	ckvil. s Signaturė	a recommended to			ville	, Ma	ryland					
190	Registr			0 4 2004	he	Jenne.	s Signature	1	par	2								

State of Maryland / Department of Health and Mental Hygien 2004 34906 For State Registrar Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** October 0 30, 2004 Anne Dumbroski 5:30A /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6923 Wick Lane Montgomery Rockville If Under 1 Year | If Under 24 Hrs Wonths Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🗙 F Director 577-01-0917 90 30, 1913 Washington. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b County 10d. Inside City Limits itam 27 la markad othar than "natural", or Itams 23a or 28a-1 ahow othar traumatic evant, the Modical Express. The traffice at 1 ☐ Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20855 6923 Wick Lane United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Accounting Telephone Company 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Johanna Leahy ٩ John A. Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If itam 27 Ian any injury or othar traun QDCB. 6920 Wick Lane, Rockville, Maryland 20855 Theresa C. McKinney/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State November 3, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland * 4 □Donation 5 □ Other (Specify) 2004 Rockville Inc. 300 West Montgomery Rockville, Maryland 20850-2805 21. Signature of Funerat/Service Licensee Funeral Home/ Avenue, 40 AR MO1386 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bullous Pemphigus Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last the attending physicien and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ eq pinous 1 Yes 2 No 3 Probably 4 ⊠Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an certificate has funeral director, page 2 : autopsy performed? 1 ☐ Yes 2X No Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Certification: To 1 X Yes 2 No 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred After 1 XNatural 5 Pending death. investigation after death Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D20148 November 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven H. Dolinski, M.D. 911 Russell Avenue, Gaithersburg, Maryland 20879-3266 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar ORIGINAL FORES DHMH 17 Rev 1/2001

			For State Registrar	State	e of Mai	yland / De <i>C</i>	partmei e <i>rtifica</i>			nd Menta		ene 	349	907
			1. Decedent's Name (First, Mid	ldle, Last)	,						ate of Death		3. Time o	
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	Examir		4a. Facility Name (If not institut	ion, give street and	d number)		4b. City	, Town, o	r Location of [Death		4c. County of D	eath	
			Frederick Me					deri				Freder	ick	
	Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔯		In yrs. last birthda 89 Yrs	Monthe	r 1 Year Days		Min. (M	te of Birth Ionth, Day, Y	Year) 9.	Birthplace (State Country)	or Foreign
	Director		581-01-9695 Usual Residence of Decedent	21						Aug	g. 25,	, 1915 Pu	erto Rio	CO
	yland		10a. State 10b. Coun	ty	1	Oc. City, Town or	Location						10d. Inside C	ity Limits
	e Ma	ctor	Maryland Fred	erick		Urbana							1 ☐ Yes	2X No
	計 or 28	Director	10e. Street and Number				10f. Zi	Code			100	g. Citizen of What	Country?	
	s 23a		3921 Sweetbria				217					SA		
	er de Items	Funeral	11. Marital Status	Arme	Decedent Eved Forces?		3. Was Dece If Yes, spe	dent of H	ispanic Origin In, Mexican, F	n? (Specify Yo Puerto Rican,	es or No- etc.)	14. Race - A Black, W	merican Indian, /hite, etc.	
36	irs aft	byF	1 ☐ Never Married 2 ☐ Married	If Yes	∕es 2∭∏No s, Give or Dates:		1 X Yes	2 No	Specify:	erto R	doan	Specify:	spanic	
Š	within 72 hours after death with the Maryland ene. then "neturel", or Items 23a or 28a-1 show ha Madigal Examirer must be molified at	ted	15. Deced	ent's Education		16a. De	cedent's Usu	al Occupa	ation		16	6b. Kind of Busine	syanic ss/Industry	
215	thin 7 e. en "n Med	pje	(Specify only nigital Elementary/Secondary (0-12	nest grade comple	ge (1-4or 5+)	life	ve kind of wi . DO NOT L	ork done d ise retired	during most of ()	f working			,	
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and But	be filed within 72 hours after death with the Marylan nat Hygiene od other then "neturel", or liems 23a or 28a-1 show event, the Medical Exactiner must be rediffed at	Be	17. Father's Name (First, Middl									aiden Sumame)		
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Baltimore, Maryland 21215-0036	d 2 sl th an th an traur		Hector Fussa/s		,							City or Town, State D 21704	e, Zip Code)	
ē,	es 1 and 2 s of Health an fitem 27 is r other trau		20a. Method of Disposition			20b. Place of Dis				ovembe		c. Location - City	or Town, State	
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a E	permit. Pages 1 s Department of He Important: If item eny injury or othe		21. Signature of Funeral Service		011							e P.O. B		
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П			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that only one cause	hat caused the	e death. Do not e	nter the mod	de of dying	g, such as cai	rdiac or respi	ratory arres	t,	Approximat Interval Bet	9
	Priysician		Immediate Cause (Final disease or condition		Asy	stole							Onset and UNKNOW	Death
34	/Medical Examiner		resulting in death)	Due	e to (or as a	consequence of):								
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	the at	sici	in the past 12 months?	4 □ P	regnant at tin		Other (sp					Month	Day *	Year
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>	S S =	o B	examiner? 1 ☐ Yes 2 ☑ No		I Inpatient	2 ER/Outpat	ent 3 🗆 DC	Othe		Death (Chec		e 6 □Other (Sp	200(64)	
Division of	ding Phy th. After thi funeral o	h:u	27. Manner of Death	28a. D	ate of Injury Month, Day Y	28b. Time		28c. Injury Work				injury occurred	эвспу)	_
Ö	Attending r death. ector: After by the funer	atlo	1001d011(tigation	world, Day 1	oar, injury	М		es 2 □ No					
Ξ	or Atter de Directo	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	mined 200. P	lace of Injury uilding, etc. (- At home, farm, : Specify)	treet, factor	, office		28f. Loc City	cation (Stree	et and Number or (Rural Route Num	ber,
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	To the within 2 To the Complet	Mec	29b. Signature and title of certif		manner stated	3.	290	. License	number	-	29d	Date signed (Mo	nth Day Year)	
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	n		30. Name and address of person		cause of deat	h (Item 23a) (Tvp	o, Print)				1.1	11 02		
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			For State Registrar		Maryland /			t of H	ealth a	nd Me	Re	g. NG. U () l ₄	3490	18
	Physici	an	Decedent's Name (First, Middle,		ouise E	vans				2	. Date of Death Month	Day	Year	3. Time of Dea	ath M
>	/Medic		4a. Facility Name (If not institution, g			-		Town, or	Location of	Death	Nover	nber 2, 20		411	
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F	Funeral		5. Social Security Number 6	. Sex 7. A	Age (In yrs. last b	irthday)	If Under Months	1 Year Days	If Under 24 Hours	Hrs. 8	. Date of Birth (Month, Day,	Year)		place (State or Fo	reign
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Mary	1 sho	ţō	Maryland	Howard				_	olumbia					1 ☐ Yes 2 🛣	
the	r 28a	rec	10e. Street and Number	Toward		-	10f. Zip		Olumbia		10	g. Citizen of V	Vhat Cou	ntry?	
5-0036 72 hours after death with the Maryland	hygiene. dother than "natural", or liems 23a or 28a-1 show event. The Medical Examber must be notified at	Funeral Director	6336 Cedar Lane						2014	14			U.S	.A.	
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D effe	lal Hygiene. d other than ' event, the Me	a	17. Father's Name (First, Middle, La	st)					18. Mother's	s Name (F	First, Middle, M.	aiden Sumam	е)		
should be	marked marked imatic ev	To B	Peter	Schaffstall							Marg	aret Well	ker		
Maryland	r Health and Menitem 27 is marke		19a. Informant's Name/Relationship	(Type, Print)	19	b. Mailir	g Address	(Street a	and Number	or Rural F	Route Number,	City or Town,	State, Zip	Code)	
	m 27 m 27 her tr		Ms. Helen Waldro	n Daug					ock Drive		tt City, Ma				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Stat	20b. Place cemet	of Dispo	sition (Nan natory or oi	e of her plac	9)	Date	_	0c. Location -	City or To	own, State	
tim	Department o Important: If any injury or once.		`4 □Donation 5 □ Other (Spe	cify)					vices, Inc	11/04	/2004	Syke	esville,	Maryland	
Bal	Impo any ir		21. Signature of Funeral Service Lic	ens	_	_ 22			s of Facility uneral H	iome F	РΔ				
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//\	ysician Medical aminer	_	shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Due to (or a	as a consequence	of):	5=0/	611		بزنجنت کو کھ	٤			Interval Betweer Onset and Death	
Records, P.O. Box 68760,	physician and s the burial-transit	dical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence										
P.O. Box 6	signed by the attending p be detached for use as I	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal deat at time of death		Ectopic pre					23d. Date Mor		ery Day Year	
S, P	gned l	by P	Part II. Other significant conditions	contributing to death	but not resulting	in the ur	derlying ca	use give	n in Part I.		23e. Did toba	cco use contr	ibute to th	ne cause of death	?
ord equire	should b		- A								1 🗆 Yes	2 🗆 No	3 Prob	ably 4. Unknown	own
Record The law require	2 62	Completed	KIERING Y	1/200-62							24a. Was an autopsy	24b. V	Vere auto	psy findings availa	able
	page	Con									performe	ed? d	eath?		
Vital	is certificate hi director, page	Be	25. Was case referred to medical examiner?	11							Check only one				
of \	드 글	2	1 Yes 2 No	Hospital: 1 ☐ Inpa				A Othe	4 Nursi		5 Residen			()	
Jung F	h. After funer	on	27. Manner of Death 1 ■ Natural 5 ■ Pending	28a. Date of In (Month, D	ay Year) 285.	Time of Injury	M	lc. Injury Work			I. Describe how	injury occurre	∍d		
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	d in by	Certification:	4 Homicide determine	building,	etc. (Specify)	arri, sar	JOE, 140(01)	Ollica		201	City or Town,		0 11012	r rioule reamber,	
To the Hospital	within 24 nours after dear To the Funeral Director: completely filled in by the		29a. Certifier (Certifying	Physician: To the bes	t of my knowledg	ge, death	occurred a	t the tim	e, date and p	place, and	I due to the cau	se(s) and mar	nner as st	ated.	
he Hc	he Fu	edical	(Check only 2 Medicel Ex	eminer: On the basis and manner s	of examination a	nd/or inv	estigation,	in my op	inion, death	occurred	at the time, dat	e and place, a	nd due to	the cause(s)	
Tor	To 1	Σ	29b. Signature and title of Certifier	off 1	2-5				number	Z.	290	1. Date signed	(Month,	Day, Year)	
	Ph		30. Name and address of person where EDDIE NAKHUDA,		death (Item 23a)		•	Y RO	ΔD	TTMO	NIUM M	ID 21	093		
	Sta	te	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature						2 011 11		<i></i>		
	Registr	-	NOV 0 4 2	004 Der	eva	9	la	-1	/						

DHMH 17 Rev 1/2001

NOVEMBER 2, 2004

State of Maryland / Department of Health and Mental Hygiene 004

34909

					Certifica	ate of Death	F	Reg. No.	. 01303
п	ath Day Y	3. Time of Death							
	Physici /Medio		John J.C	Hovers	R.		Ochber	30 200	2:15 AT
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death	4c. County of	Death
			KOLAND TOR	1C-Place		Both	imore		
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs.	Month	ber 1 Year 11 Under 24 Hr s Days Hours Mir		, Year)). Birthplace (State or Foreign Country)
	Director	12	44-26-3887	85	Yrs.		8-3-	19 5	outs (arolina
	pu *		Usual Residence of Decedent 10a. State 10b. County	10c Ci	ty, Town or Location				10d Ingido City Limite
	anyla shor	_	A COUNTY						10d. Inside City Limits 1 12 Yes 2 □ No
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	if the	ji	10e. Street and Number		10f. 2	Zip Code		10g. Citizen of Wh	at Country?
	123a	20	806 N. Linus	DOD AVEN	ue.	41205		US	4
	r deg	Funeral Director	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	,S. 13. Was Da	edent of Hispanic Origin? (pecify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race -	American Indian, White, etc.
0	afte or h		1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		2 No Specify:	·	Specif	N
21215-0020	within 72 hours after death with the Maryland ene. than "natural, or Items 23a or 28a-f show he Modical Examiner must be notified at	Completed by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:				Spooling.	Black
7	72 t	ete	15. Decedent's Ed (Specify only highest gra	ucation de <i>completed)</i>	16a. Decedent's Us (Give kind of	sual Occupation work done during most of we use retired)	orking	16b. Kind of Busin	ness/Industry
121	ithin le li	면	Elementary/Gerlondary (0-12)	College (1-4or 5+)	10000		,	- My	PING
	filed withi Hygiene. wher than	S	940		L0/1621	poreman	1	Locus	Stry
n n	tal H d off	Be	17. Father's Name (First, Middle, Last)	7/		18. Mother's Na	ame (First, Middle,	Maiden Sumame)	
7 3	should be nd Mental marked of	ဥ	reda el	HOVER	_	K050	yee	UUN	YOLD
Maryland	2 shc end ls me		formant's Name/Relationship (7	ype, Print)	19b. Mailing Addra	uss (Street and Number or F	Rural Route Numbe	r, City or Town, St	
e, N	1 and 2 Health em 27 I	-	JOHN Gover	JR (SON)	7/10H	rews ourt	Newtr	eedom,	PA 17349
Ore	Set		20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □		Place of Disposition (A cemetery, crematory	lame of other place	PI Date	20c. Location - Ci	ty or Town, State
Baltimor	permit. Pages Department of I Important: if Ite eny Injury or or		4 □ Donation 5 □ Other (Specify		chuen Vo	Men Cemeter	12/04	10WSC	N,/M/
alt	permit. Departn Imports eny Injt		21. Connature of Funeral Service Lice	ee	17/200	r SQ Facility	0010 To	. 2000	SeriesPA
m	permi Depa Impo eny Ir		XXIII ALLIYY	Man As	100	LI CONTO	1 2011	ALD S	IN LAN
	_		23a. Party. Enter the disease, or comp	lications that caused the deat	h. Do not enter the m	ode of dving, such as cardia	ac or respiratory ar	rest.	Approximate
	Physician		23a. Farty. Enter the disease, or companies the control of the con	one cause on each line.		,	,		Approximate Interval Between Onset and Death
	/Medical		Immediate Cause (Final	a. Ischemic Due to (c	BALA	111. 202 VP			Ima. V
	Examiner		disease or condition resulting in death)	a. To Cherico	e cartai	aujogara	y		meath
		ē		Due to (c	or as a consequence of	1): /			husin
	uted ansit	Examiner		b	or as a consequence o	y araces	e		Maurice
~	exection of the second of the	Exa	if any, leading to immediate	Due to (c	or as a consequence of	i p			
68760,	n certificete be executed inding physician end use es the buriel-transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Let	C		Α.			
89	ficete phy s the	n/Medicai	resulting in death) Last	Due to (o	r as a consequence o).			
X	certing ding	3		d					
m	eath etter I for u								
Ö	the d the ched	Physicia	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Part I.			bute to the cause of death?
P.0	thet t	돈					1 U Y	es 2⊡1No 3	☐ Probably 4 ☐ Unknown
Records,	The law requires thet the death ate has been signed by the etter page 2 should be detached for t	d by					24a. Was a	on autonou 2	24b. Were autopsy findings
Ö	requ	etec					perfor		available prior to
Şeç	elaw hast je 2 s	Completed	Mr. off						completion of cause of death?
=	ystclan: The last certificate he director, page	S					1 🗆 Y	es 2 🗆 No	1 ☐ Yes 2 ☐ No
of Vital	Attending Physician: The or deeth. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?				fath (Check only or	ne)	
Ę		ပ္	1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□		Home 5 ☐ Resid	ence 6 Other	(Specify)
2	og Ph ter th neral		27. Mann Death 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe h	ow injury occurred	
<u>Ö</u>	eeth.	atic	2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No			
Division	er de recto	ti li	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, street, factor)	ory, office	28f. Location (S City or Town		or Rural Route Number,
	rs aft	Certification:		- Silver (opoor					
	hound hound ify fill		29a. Certifier 1 Certifying Phy	sician: To the best of my kno	wledge, death occurre	d at the time, date and plac	e, and due to the c	ause(s) and mann	er as stated.
	To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After th completely filled in by the funeral	edicai	one)	iner: On the basis of examina and manner stated.	and and investigation	ar, in my opinion, death occ	uneu at the time, t	ate and place, and	Tude to trie cause(s)
	with To ti	≥	29b. Signature and title of certifier	Ta. A	4. 2	9c. License number	2	9d. Date signed (A	Month, Day, Year)
	1		M. Habelle	the yreger	ris	013657			
	0		30. Name and address of person who o	ompleted cause of death (Item	n 23a) (Type, Print)	Δ.			
	~		M- ISABELLE M	inespected cause of death (item	30 W. 40 Y	STREET, BAL	-TITTORE)	170212	-11
	Sta	te	31. Date filed (Maph Day, Year) 20	14 32. Registrar's Signs		parket			
	D :		COLUMN TO THE CO	14.75	18	1 12 12 12 1			

			1 - For State Registrar			f Marylar	nd / Dep		t of H	lealth a	and M	ental Hy	giene Reg. No	ZUUU		910
	Physici /Medi		1. Decedent's Name (F			Green		·				2. Date of De Month	Da Dev	2 200		of Death 34 PM
	Examir		4a. Facility Name (If no							Location of	of Death		4c	. County of Dea	ith	
	Funeral		Stella Ma			7. Age (In yrs.		If Under	1 Year	ore If Under		8. Date of Bi	rth	N/A 9. Bi	thplace (State	or Foreign
	Director		214-56-91		1 X X 2□F	51	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 12-7-	-52	Ba	Ltimor	e,Md
	and		Usual Residence of De- 10a. State 10	cedent b. County		10c. Ci	ty, Town or L	ocation							10d. Inside (City Limits
	Maryl -f sho	tor	Md.	N/A			Balti									s 2 No
	ih the or 28a	Director	10e. Street and Numbe					10f. Zip	Code				10g. Cit	tizen of What C	ountry?	
	ath wi	rai D	3414 Au	rora					L207				USA			
	hours after death with the Maryland turel', or Items 23a or 28a-f show al Exarte format by notified at	Completed by Funeral	11. Marital Status 1 ☐ Never Married	X Marrie	Armed Fo	ident Ever in U rces?	I.S. 13.			ispanic Ori in, Mexican	gin? (Spe 1, Puerto f	cify Yes or N Rican, etc.)	0-	14. Race - Am Black, Whi		
>> 036	urs af	by F	3 Widowed 4		If Yes, Giv Year or Da	е		1 🗆 Yes	2 <mark>∰</mark> No	Specify:				Specify: B	lack	
2.0	72 ho 'netur	eted	15. (Specify o	. Decedent's	Education grade completed)		16a. Dece	dent's Usua kind of wo DO NOT u	al Occupa	ation during mos	t of workir	ng	16b. K	ind of Business	/Industry	
721	within ane. then "	du	Elementary/Seconda		College (1	-4or 5+)	1	<i>DO NOT u</i> S ici a		1)			P	Band		
200	Hygie other ent,	Be Co	17. Father's Name (Firs		ast)		1		T	18. Mothe	er's Name	(First, Middle				
/lan	uld be Mental Irked o	To B	James	C.	Gree	n				An	neti	ta (Gree	en		
Green, Jan Maryland 21215-0036	2 sho and I is me	Ì	19a. Informant's Name											or Town, State,		1 007
	1 and Health em 27 ther t		Marcia 20a. Method of Disposit		n Wife	20b. I	3414 Place of Disp cemetery, cre					ã⊥∵lm(ate		Maryla		1207
Š.	Pages ent of nt: If it		1 X Burial 2 □ C 14 □ Donation 5 □	remation 3		Sidle	cemetery, cre t . Zie				1/9-	-04		sdrow		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23a or 28a-f show any injury or other treumetic event, the Mardical Examt incrinual by morfilled at once.		21. Signature of Funera	al Service Li	censee	112					The second second second					
_	89 5 8		Lloyd	1 m	Step									Ser,P.A	2121	.7
				illure. List or	omplications that can't one cause on e	aused the dea ach line.	th. Do not en	ter the mod	e of dyin	g, such as	cardiac or	respiratory a	arrest,		Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aıı	a		Dw2	tute		cont	c					
	Examiner				Dus 10 (or as a consec	quance or):									
	P =	iner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Lissass or in)	ions, diate ng	Due to (or as a consec	luence of):									
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last		c. Due to (or as a consec	mence of):				_				11	
760,	The law requires that the death certificate be executed at has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ical E			d		120.100 01/1									
99	death certiticate to attending physical for use as the the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the total for the forth for the total for the forth for the forth for the forth forth for the forth f				0.		777.2						-			
Вох	ath cer ttendir or use	Physician/Med	23b. Was decedent pre in the past 12 mor			irth 2 Feta	al death 3	⊒Ectopic pr						23d. Date of de	livery Dav	Year
P.O. E	that the dealed by the and detached for	ysic	1 Yes 2 No		4☐ Pregn 9☐ Unkno	ant at time of o	death 5{	Other (sp	ecify)				1	WORL	Day	1001
	es that tigned by	by Ph	Part II. Other significan	nt condition	s contributing to de	ath but not res	sulting in the u	ındərlying c	ause give	en in Part I.		23e. Did	tobacco u	use contribute t	the cause of	death?
rds	w requires been sign											1 🗆	Yes 2	ØN₀ 3□P	robably 4]Unknown
oco	ne law requ has been ge 2 should	Completed										24a. Was			utopsy findings completion of	
<u>~</u>		Con										perfe 1 🗆 Yes	ormed? 2☑No	death?	2 10	
V.	Physicien: this certition ral director, i	o Be	25. Was case referred examiner? 1 Yes 2 No	to medical	Hospital:	npatient 2	ER/Outpatie	nt 3 🗆 DC	Othe			(Check only		. F.G	w. 1	
o o	ding Phy th. Atter this funeral d	<u>- </u>	27. Manner of Death	n b vi		of Injury h, Day Year)	28b. Time o		8c. Injury Work	4 - 140		e 5 ⊟ Hes 8d. Describe		6 ⊠Other (Spe y occurred	city) (\S	ACC
sior	Attending r death. ector: Atterby the funer	atio	2 Accident	Pending investiga	tion	ii, Day 16ai)	піјшу	М		Yes 2 □ i	No					
Division of Vital Records,	in the	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could no determin	ad 286. Place	of Injury - At h	ome, farm, st fy)	reet, factory	, office		2	8f. Location (City or To		d Number or R)	ural Route Nur	nber,
	To the Hospital within 24 hours a To the Funeral Completely filled		29a. Certifier 1-P	Certifying	Physician: To the	best of my kno	owledge, deal	h occurred	at the tim	ne. date an	d place, a	nd due to the	cause(s)	and manner a	stated	
	the Hospital	Medical	(Check only 2 one)	Medical E	xaminer: On the ba and mann	asis of examina	ation and/or in	vestigation	, in my op	oinion, deat	th occurre	d at the time,	date and	place, and due	to the cause(s)
	Vithii To ti	M	29b. Signature and title	of certifier	^			290		number				te signed (Moni		
			P 571	11	0~			1	740	854			41	2/200	9	
1	0		30. Name and address	of person w	ho completed caus	e of death (Iter	n 23a) (Type,	Print)	30.10	lina	-	22 -1	7	1295		
/1	Sta	ate	31. Date filed (Month, L	Day, Year)	32. R	egistrar's Signa	ature	111		1100	01 6	II COL.		,		
1)	Regist	rar	NO	V 0 4	2004	seneva	· 19	1	POLE	1						

		•	1 - State of Marylar State of Marylar	nd / Depa <i>Cer</i>	rtment of H tificate of L	ealth a Death		eng 004	34911
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death Month	Day ST Year	3. Time of Death
5	/Medic	al	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of	MOVEMBER	4c. County of Deat	. 4.50 M
	Examin	er	NORTHWEST HOSPITAL CENTER		RANDALL			BALTIMOR	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday) 4 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	8. Date of Birth (Month, Day)	9. Birt	hplace (State or Foreign untry)
	ס		Usual Residence of Decedent	ity, Town or Lo					
	Aaryla F ehov	or	MD BALTIMORE 10c. Co		GS MILLS				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the h	Director	10e. Street and Number	ONTH	10f. Zip Code		100	g. Citizen of What Co	untry?
	th with	ai D	619 HAMMERSHIRE ROAD			21117			USA
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Orig n, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Hyarithan "natural", or lieme 23a or 28e-f ehow hth the Medical Evant or must be notified at	by Fu	1 □ Never Married 2 □ Married 1 □ Yes 2 🕅 No If Yes, Give Year or Dates:	1	∏Yes 2∭X No	Specify:		Specify:	WHITE
2-0	72 ho 'natur disel	Completed by	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occupa	durina most	of working	6b. Kind of Business/	Industry
121	within ene. than	mp	Elementary/Secondary (0-12) College (1-4or 5+)		OO NOT use retired MAKER)		OWN HOME	
Q	filed Hygie other ant,	Be Co	17. Father's Name (First, Middle, Last)	HOHE	IVINLIN	18. Mother	r's Name (First, Middle, Ma		
ylan	Mental Mental arked etic ev	To B	JULIUS	MAZO		ROS			MLENICK
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Merdral Hygiene. Importent: if item 27 is marked othar than. Instural; or itema 23a or 28e-f show any figury or other traumetic evant, the Medical Examinating must be notified at angle.		19a. Informant's Name/Relationship (Type, Print) NORMA KATZ / DAUGHTER				r or Rural Route Number, (DAD - OWINGS		
ore,	es 1 al of Hea litem		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State	Place of Dispos cemetery, cren	sition (Name of natory or other plac	e)	Date 20	c. Location - City or	Town, State
Ĕ	Page ment cant: the		`4 □ Donation 5 □ Other (Specify) ADA				11/3/2004		MORE, MD
Baltimore,	permit. Depart Import any inj		21. Signature Funeral Service Licensee				SOL LEVINSO WN ROAD - PI		
			23a. Part1. Enter the disease, or complications that caused the dea shock, of heart failure. List only one cause on each line.	th. Do not ente	er the mode of dying	g, such as o	cardiac or respiratory arres	t,	Approximate Interval Between
,	Pnysician		Immediate dause (Final disease or zndition aa.	MEU	MONIA	1			Onset and Death
	/Medical Examiner		Due to (or as a conse	quence of):					
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	quence of):					
	certificate be executed adding physician and use as the burial-transit	Examine	that initiated events c. Due to (or as a consecution in death) Last Due to (or as a consecution in death)	quence of):					
8760,	s be ex		355 to (57 45 4 557 557	4001100 017.					
9	tificate ig phy as the	ledic							
Вох	leath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fet.		Ectopic pregnancy			23d. Date of deli	very Day Year
0	0 0 0	Physician/Medical	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 1 □ Yes 2 No 9 □ Unknown	death 5	Other (specify)			Month	Day 1 Bai
s, P.	s that the dined by the detached	by Ph	Part II. Other significant conditions contributing to death but not re-	sulting in the ur	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rds	w requires that been signed I should be det						1 ☐ Yes	2 No 3 Pr	obably 4 Unknown
Vital Record	4 × C/	ompleted					24a. Was an autopsy	prior to d	topsy findings available completion of cause of
a H	Th ate pag	O						d? death? No 1 ☐ Yes	2 No
Ž	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2] ER/Outpatien	t 3 DOA Othe	ar.	of Death (Check only one) sing Home 5 Resident	ce 6 □Other (Spec	ntv)
J Of		-	27. Manner of Death 28a. Date of Injury	28b. Time of Injury		at at	28d. Describe how		any)
sior	Attending r death. actor: After by the fune	catlo	2 Accident investigation	,,		Yes 2 N	10		
Division	or Attendation of Attendation of Director:	ertification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At he building, etc. (Special Could not be determined 29c.)	nome, farm, stre ify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Al within 24 hours after of To the Funeral Dirac completely filled in by	0	29a. Certifier 1 Certifying Physician: To the best of my kn	owledge, death	occurred at the tim	ne, date and	d place, and due to the cau	se(s) and manner as	stated.
	he Ho in 24 I ihe Fu pletely	edical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or inv			h occurred at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	a m.c	29c. License	9 number		L. Date signed (Month	ST 2004.
7	S		0.0					overno 01	1 4004.
4	110		30. Name and address of person who completed cause of death (Ite MENTHUEST HESPITM CENT		2001			133.	
	Sta		31. Date filed (Month, Day, Year) \$2. Registrar's Sign		bould	Land	1110		
	Registr	ar	NOV 0 4 2004	1- 14					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Physician Month ANNA October 31, 2004 /Medical 11:35 PM 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Catonsville

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Yeer) St. Joseph Nursing Home Baltimore 5. Social Security Number If Under 1 Year 7. Age (In yrs. lest birthdey) **Funeral** Birthplace (State or Foreign Country) Days 1 □ M 2 X F Months 219-42-3115 Yrs 93 Director June 20, 1911 Maryland Usuel Residence of Decedent parmit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylend Department of Heelth and Mantel Hyglana. Important: if item 27 is marked other than "natural", or items 23a or 28e-f show apply injury or other traumatic event, the Madical Examiner must be notified at ORGs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Director Baltimore Catonsville 1 ☐ Yes 2¶ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1222 Tugwell Drive 21228 Funeral USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Married Saitimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 Nidowed 4 Divorced Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) secretary <u>federal government</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael James Sullivan ဂ္ Rose Mae Laffy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nancy Bateman/daughter 2117 Edmondson Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 X Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee North Tolhard & Wade State Anatomy Board 655 W. Baltimore Street Di/rector Baltimore, MD 21201 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NEUMONIA DAYS Examiner Due to (or as a consequence of) Physician/Medical Examiner ettending physician and if for usa as tha burial-trensit The law requires that the deeth cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Last Due to (or as e consequence of) baan signed by the e should be dateched t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown ARTERY ORONARY þ ceta has baan sig pega 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? HEART FAILURE 1 🗆 Yes 2 NO 1 ☐ Yes 2 ☐ No or Attending Physician: To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funerel Director: After this cartifica completely filled in by the funeral director, 25. Wes case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: P 1 Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: 27. Menner of Deeth . Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 ☐ Pending 2 ☐ Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner steted. edicai 29a. Certifier (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) D40012 NOVEMBER 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) ROAD | SUITE 204, CATONSUICE, MD 21228 MO 405 FREDERICK TOS KOUTON 31. Date filed (Month, Day, Year) 32. Registrer's Signature State NOV 0 4 2004 Registrar

DHMH 16 Rev 6/95

ORIGINAL

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			1 - For State Registrar	State of M	larylar	id / Depa	artme rtifica	nt of Hea	alth and eath		Reg. No.		34913
	Physici	ian	Decedent's Name (First, Middle, La							2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Theda R. Ho 4a. Facility Name (If not institution, given		•}		4h Cit	v Town or Lo	cation of Deat	Octobe		, 2004 County of Dear	11:30 AMM
	Examin	ner	1320 Paper		,			Cockey			10.	Baltim	
H	Funeral	1000	5. Social Security Number 6. S	Sex 7. A	ge (In yrs.	last birthday)	If Und	er 1 Year If	Under 24 Hrs	8. Date of Bir	th Voas	9 Bird	
	Director		220-30-3091	I□M 2X)F	81	Yrs.	Month	S Days H	Hours Min.	Oct 9,	192	3 Ne	thplace (State or Foreign buntry) W York
	and *		Usual Residence of Decedent 10a, State 10b, County		10c Cit	ty, Town or Lo	cation						10d. Inside City Limits
	Aaryla Febo	5	MD Baltin	nore		Cockey		1e					1 ☐ Yes 21 No
	the the	Director	10e, Street and Number		1			ip Code			10a. Cit	izen of What Co	ountry?
	3a or		1320 Paper Mill	Road					21030		•	USA	•
	deati	Funeral	11. Maritat Status	12. Was Decedent Armed Forces	t Ever in U	.S. 13.	Was Dec			Specify Yes or No to Rican, etc.)	>-	14. Race - Ame Black, Whit	
3	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23e or 28e-f ehow he Madical Exemirer must be notified a	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X☐ If Yes, Give Year or Dates:	No				Specify:	to rilean, etc.)			white
3	2 hour	led t	15. Decedent's E	ducation		16a. Dece	dent's Us	ual Occupatio	n		16b. Ki	nd of Business/	/Industry
213-0090	within 73 ene. then 'na	Completed	(Specify only highest gr Elementary/Secondary (0-12)		5+)	(Give	kind of v DO NOT	ork done durii use retired)	ng most of wo	orking			
7	77 00 5 5	Con	12	College (1-4or 5+			ph	ysicia				medic	al
2	0 = 0 =	Be	17. Father's Name (First, Middle, Last Earle C. Henry					18		me (First, Middle			
y o	should be nd Mental marked	2				105 14-25	- 8 - 1 - 1			eburn Bi			7 0 41
Ma	d 2 st th and 7 ls n traun		19a. Informant's Name/Relationship (Edward Hopkins/s)	-						ural Route Numb			
ָ ט	Heal Heal tem 2		20a. Method of Disposition	70430	20b. F	Place of Dispo	sition (N	ame of	ı Koad	Cockeys		e MD	
Dalimore,	Pages nent of int: If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ፟ Donation 5 ☐ Other (Speci	Removal from State	• "	cemetery, cren	natory oi	other place)					
בפור	permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 is marked eny injury or other traumatic et <u>once</u> .		21. Signatur, Figureral Service Lice RONAL S	Wade, ir	ecto	r St Ba	Name ate	Anatom	of Facility D Boar	d 655 W.	Ba1	timore	Street
ă	E Sin		23a. Part1. Enter the disease, or cord shock, or heart failure. List only	plications that cause one cause on each	d the deat								Approximate Interval Between
_% −	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Alzh	eim	er's		seas					Onset and Death 14 years
	Examiner			Due to (or as	s a conseq	uence of):							,
7.9	.	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	s a conseq	uence of):							
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
5	licate be executed physician and s the burial-transit	cai E	Todaling in county East	Due to (or as	s a conseq	uence of);							
	physics the l	edica		_ d									
\ \ \ \	certif nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome								23d. Date of deli	iverv
	that the death certif ed by the attending detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1☐Live birth 4☐Pregnant a			JEctopic Other (pregnancy specify)				Month	Day Year
	at the by th	hys	9 Unknown	9□ Unknown									
-	tw requires that the s been signed by th should be detache	by	Part II. Other significant conditions Coronary			1 -		-	n Part I.				the cause of death?
5	requi	eted	Coronary	ar. I Er		9136	250					₹140 3 Pr	————————————
VICE IICOOLGS	The law ate has b bage 2 st	ompleted								24a. Was autoj	an osy ormed2	24b. Were au prior to death?	topsy findings available completion of cause of
3		e Co	25. Was case referred to medical							1 ☐ Yes	2 🗹 No	1 ☐ Yes	2 1 No
	sicia s certi irecto	o Be	examiner?	Hospital: 1 ☐ Inpati	oot 2 🗆	ER/Outpatien		0.0		ath (Check only of dome 5 Residence			-4.1
5	g Phy er this eral d	-	27. Manner of Death	28a. Date of Inj.	ury	28b. Time of	301	28c. Injury at Work?		28d. Describe			ory)
5	ath. rr: Aft	atio	1 Natural 5 Pending 2 Accident investigation	n	ay rear)	Injury	М		2 🗆 No				
	al or Atters all all all all all all all all all al	ertification;	3 Suicide 6 Could not be 4 Homicide determined		njury - At he etc. <i>(Specif</i>	ome, farm, str	eet, facto	ry, office		28f. Location (City or To	Street and wn, State,	d Number or Ru)	ral Route Number,
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certifica completely filled in by the funeral director.	edicai C	29a. Certifier 1 Certifying Pl (Check only one)	nysician: To the best miner: On the basis and manner s	of examina	wledge, death tion and/or inv	occurre estigation	d at the time, on, in my opinion	date and place on, death occu	e, and due to the urred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier			/		9c. License nu			29d. Dat	e signed (Month	n, Day, Year)
			hum h			1 MD		0184	10		10	128/0	4
			30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type,	Print)	0 1	1.4	. //		D =:	
V	Sta	oto.	Laura M Mumf	32. Regist	rar's Signa	ture	115	load,	LUTH	erville	19	V 210	193
	Sta Registr		MOV O 4 2004	hender	~	19 1	-	1					

State of Maryland / Department of Health and Mental Hygien 2004 34914 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year **Physician** John Jones 26, October 2004 12:00 AM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 47 E. North Avenue Hagerstown Washington 5. Social Security Number unk 6. Sex If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 X M 2 ☐ F Director 83 24, 1922 Maryland Usuel Residence of Decedent the Maryland 10b.County Washington 10a State 10c. City, Town or Location 10d. Inside City Limits or 28e-f ahow f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28e-f ahov other treumstic event, the Modical Examinar must be notified at Hagerstown Director 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 47 E. North Avenue 21740 USA Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 □ No If Yes, Give Year or Dates: 141-45 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: 3 ☐ Widowed 4 🎇 Divorced black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) custodian board of education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Jones ပ Lorene Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ina L. Rock/friend 750 Dual Hgwy #131 Hamerstown, MD 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ite any injury or oti once. 1 □ Burial 2 □ Cremation 3 □ Removal from State 21. Shantur - Funeral Service Licensee Konall S. Wade 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 man 23a. Party. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aseres /Medical Due to (or as a consequence of): Examiner TERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. the detached 9 Unknown 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 2 🗆 No 1 TYes To the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home Signature 6 Other (Specify, 1 ☐ Yes 2 No P 2 2 X ER/Outpatient 3□ DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of After 5 Pending investigation Natural 2 Accident Injury s after deceing and Director: After the fr 1 ☐ Yes 2 ☐ No within 24 hours are.
To the Funerel Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIUWA SOMM 11110 mesic. 7 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 4 2004

			For State Røgistrar	State of Ma	aryland / Depa <i>Cel</i>	artment of H <i>rtificate of l</i>	lealth and M Death	iental Hy	gien 2004	34915
	Physicia	an	1. Decedent's Name (First, Middle, La.	,				2. Date of De	ath Day Year	
No.	/Medic	al	GEORGE LINWOOD 4a. Facility Name (If not institution, giv.)	KING		4b. City. Town or	Location of Death	Octobe	er 30, 2004 4c. County of De	
	Examin	er	Johns Hopkins Bay		cal Center	Baltim			N/A	
	Funeral		Social Security Number 6. S	ex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da AUGUST	th 9. Bi	rthplace (State or Foreign country)
	Director		219-28-5527 Usual Residence of Decedent		72 *rs.			AUGUST	3,1932	MD
	nryland show	_	10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	the Ma 28e-f	Director	MD BALTIMO	ORE	DUNDAL	10f. Zip Code			10g. Citizen of What O	1 XYes 2 No
	3a or		643 S. AVONDALE 1	ROAD		212	22		USA	ountry :
	ems 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		ecify Yes or No Rican, etc.)		
36	be filed within 72 hours after death with the Maryland ital Hygiene. od other than "netural", or items 23a or 28e-f show of other than "netural", or items 23a or 28e-f show event, the Mcdical Exprimer must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ N If Yes, Give Year or Dates:	lo	1□Yes 2□XNo	Specify:		Specify:	BLACK
21215-0036	2 hour	ted t	15, Decedent's E	ducation	16a Dece	dent's Usual Occupa	ation	·	16b. Kind of Busines	
218	ithin 7 ne. "nan"n	Completed	(Specify only highest gra	College (1-4or 5	+) life.	DO NOT use retired	ouring most of work ()	ing		
2	e filed within al Hygiene. other than '	e Cor	11 17. Father's Name (First, Middle, Last,)	PAI	NTER	18. Mother's Name	e (First, Middle.	Maiden Sumame)	STEEL
lan	should be nd Mental marked o matic eve	To Be	DOLPHUS KING				ALICE I			
Baltimore, Maryland	2 m m m		19a. Informant's Name/Relationship (er, City or Town, State, MD 21222	
ē,	is 1 and of Health item 27 other tr		LAKEESHA KING/GR.	ANDDAUGHIE	20b. Place of Dispo	AVONDALE sition (Name of	! .	TIMORE,	20c. Location - City o	
E O	00		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1	matory or other plac E NATIONA		5-2004	BALTIMORE	E, MD
alti	permit. Page Department Importent: Il eny injury o		21. Signature of Funeral Service Licer	ns <i>e</i> e	1					NS F.H., INC.
	₹0 E 5 a		James G	Mor		701-31 LA			•	21217 Approximate
	Physician		23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each lir	1 1 1 2	N N .		or respiratory ar	1031,	Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	aOW\ Due to (or as	a consequence of):	vd to Leg)			
U	Examiner	<u>.</u>	Sequentially list conditions,	b. Dua to (or as	a consequence of):					
	uted 3 ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Ellar Urbarying Cause (Disease or injury that initiated events	Dub to (or as	a consequence orj.					
oʻ	e exectian and and and and and		resulting in death) Last	Due to (or as	a consequence of):					
68760,	ificate be executed g physician and as the burial-transit	edlcal		_ d						
Box 6	± po a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		7-			23d. Date of de	elivery
-	the death cer y the attendir iched for use	Physician/M	in the past 12 months? 1 \(\text{Yes} \) 2 \(\text{No} \)	4□Pregnant at		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	that the de led by the detached		9 ☐ Unknown Part II. Other significant conditions of	contributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
Records,	8 50	ed by						1 🗆 ነ	res 2 No 3 ☐ F	robably 4 Unknown
900	e law requir has been si je 2 should l	ompleted						24a. Was		utopsy findings available completion of cause of
E B		Con			· · · · · · · -			perfo	rmed? death? 2☐ No 1XYe	·
Vital	Attending Phyeicien: Thradenth. r death. sctor: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1	Hospital: 1 ☐ Inpatie	nt ZEER/Outpatier	nt 3 DOA Othe	26. Place of Death		ne) dence 6 □Other (Sp	ng(ft/)
ιof	ding Phye h. After this funeral di	\vdash	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju			7-307		now injury occurred	
Siol	uttendir death. ctor: Af y the fu	catlo	2 Accident investigatio	10/30/04	8:10 1	P M 1□	Yes 2 No	rdoc	ect wi	45 S HOT
Division of	e di C	Certification;	4 Homicide determined		ury - At home, farm, sti c. (Specify)	11/		City or Tow		ALE AN CAVER
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Pt	nysician: To the best of	of my knowledge, deat	h occurred at the tim	ne, date and place,	and due to the	cause(s) and manner a date and place, and du	s stated.
	the H hin 24 the Fi mplete	Medical	one)	and manner sta	ited.	29c. License			29d. Date signed (Mon	
	7. 7. 0.0		29b. Signature and title of centrier	M. A.		Loo. Liberta	O.C.M		October 31	
	IXL		30. Name and address of person who	completed cause of d		-				
	Υ.		JACK M	Tru Mi	(). 11:	Penn St	reet, Bal	timo <u>re</u> .	Maryland :	21201
	Sta Registr		31. Date filed (Month, Day, Year)		ar's Signature	1.	,			

		Registrar		Manylance/3Dep Ce	rtificate of	Death	R	leg. No.	0 7 5 1	
Physici /Medic			ANCY	В.		KATZ	2. Date of Dea	R 31, 2		
Examir	ner	4a. Facility Name (If not institution, giv 725 MT. WILSON			4b. City, Town,	or Location of De	LLE	4c. County	of Death BALTIMOR	
Funeral Director		L13 00 3017	Sex 7. 1 □ M 2 F	Age (In yrs. last birthday 88 Yrs.	Months Days			,1916	Birthplace (State or Fore Country) MD	
show	or	Usual Residence of Decedent 10a. State 10b. County	AL TIMODE	10c. City, Town or L	ocation	DIVECUI			10d. Inside City Lin 1 ☐ Yes 2 ☑	
a or 28a-f	Direct	10e. Street and Number	ALTIMORE		10f. Zip Code	PIKESVI 21208		10g. Citizen of What Country?		
"natural", or Itams 23a or 28a-f show cdical Exercitivati Le modified at	by Funeral Director	725 MT. WILSON LA 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	X No	Was Decedent of If Yes, specify Cul	Hispanic Origin? ban, Mexican, Pue	Specify Yes or No- nto Rican, etc.)	14. Race Blac Specify	e - American Indian, k, White, etc.	
be filed within 72 no ital Hygiene. Id other than "natur avant, II a Medical	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4)	(Give	edent's Usual Occu e kind of work done DO NOT use retire OR	ed) during most of w		JOURNAL	of Business/Industry	
nd Mental H markad oth	To Be	17. Father's Name (First, Middle, Last, A.	STANLEY	BRAG	ER	18. Mother's N	ame (First, Middle, i	Maiden Sumam L.	LEOPOLD	
Ith ar 27 Is r trau	ľ	19a. Informant's Name/Relationship (DEBORAH RABIN /	Type, Print) DAUGHTER	19b. Mail 6 Ru	ing Address (Street of DY FIELD	ot and Number or I	Rural Route Number	E, MD 2	State, Zip Code) 1209	
0		20a. Method of Disposition 1 X Burial 2 Cremation 3 C 4 Donation 6 Other (Specific		20b. Place of Disp cemetery, cre BALTIMOR	matory or other pla		Date	20c. Location -	City or Town, State	
Department Important: I any injury o		21. Sign var uneral/Service Live	hus	ev 8	900 REIS	TERSTOWN	OL LEVINS ROAD - P	IKESVIL	OS., INC. LE, MD 21208	
Medical xaminer transit the private transit tr	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a consequence of): as a consequence of): as a consequence of):		ng, such as cardi	ac or respiratory arm	est,	Approximate Interval Batweer Onset and Deatl Utophe	
by the attending I tached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgnths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		n 2 ☐ Fetal death 3 [t at time of death 5 [⊒Ectopic pregnand □ Other (specify) _	су		23d. Date Mon	of delivery th Day Year	
been signed b should be deta	by	Part II. Other significant conditions of	contributing to death	h but not resulting in the t	inderlying cause g	ven in Part I.	23e. Did tot		bute to the cause of death	
ate has	Completed	<u> </u>					24a. Was a autops perform 1 \(\text{Yes} \) 2	ned? pi	/ere autopsy findings availa rior to completion of cause eath? □ Yes 2□ No	
ir death. ector: After this certificate by the funeral director, pag	ation; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of li (Month,	atient 2 ER/Outpatie	of 28c. Inju	her: 4 Nursing	eath Check on on Home 5 Reside 28d. Describe ho	ence 6 Othe		
s after death. II Director: A od in by the fu	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, office		28f. Location (St. City or Town	reet and Numbe n, State)	r or Rural Route Number,	
o 24 hours after Properties Price Petely filled in D	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exer	nysician: To the be niner: On the basis and manner	est of my knowledge, deal s of examination and/or in stated.	h occurred at the to exestigation, in my	ime, date and plac opinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and man ate and place, a	oner as stated. and due to the cause(s)	
in ale	Σ	29b. Signature and title of certifie			29c. Licen	se number	2:		(Month, Day, Year)	
within 24 ho To the Fund completely f		30. Name and addres of person d	Zr.	23		10371		n/il	cy	

State of Maryland / Department of Health and Mental Hygiene 2004

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			Certificate of Death	Reg. No.
		Decedent's Name (First, Middle, Last)	V - 12	2. Dete of Deeth Month Dey Year 3. Time of Death
	Physician /Medical	Kenneth Ernest	KNIGHT, SR	OCT 30 2004 7:30 fm
	Examiner	4e Fecility Neme (If not institution, give street end number)	4b. City, Town, or L	1
		Westminster Nursing	3 Home Wesimi	nsteil CARROLL
	Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs. lest birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Dey, Year) 9. Birthplace (State or Foreign Country)
	Director	217166710 1×M 20 F 7	Yrs. Months Bays House	FEB 2 1926 MARYLAND
	g	Usuel Residence of Decedent		
	how how		c. City, Town or Location	10d. Inside City Limits 1. ✓ Yes 2 □ No
	e Ma	MO CARROLL	Westminstell	IATes 2∐No
	or 28	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	15 will will will will will will will wil	1234 WASHINGTON KO	cad 21157	USA
	be filad within 72 hours after death with the Maryland tal Hygiane. d other than "natural", or items 23e or 28e-f show event, the Medical Examiner must be northed at Second Completed by Funeral Director	11. Maritel Status 12. Was Decedent Ever Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.) 14. Race - American Indian, Black, White, etc.
0	or the	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1□Yes 2⊅No Specify:	Specify: 1 1 1
5-0020	ral ral	3 Widowed 4 □ Divorced Year or Dates:	145	White
5	"natural", "natural", edical Exe	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's Usual Occupetion (Give kind of work done during most of work life. DO NOT use retired)	king 16b. Kind of Business/Industry
21		Elementery/Secondary (0-12) College (1-4or 5+)	- /	
21	filad with Hygiane. ther than ent, the b	10 0	E/ECTRICIAN	Commercial
n	d offi	17. Fether's Neme (First, Middle, Lest)		ne (First, Middle, Maiden Sumame)
<u>X</u>	should be filad within and Mental Hygiane. marked other than ametic event, the Maratic ev	Clarence KNIGH		
Maryland	and and series	19a. Informant's Name/Relationship (Type, Print)	0	rel Route Number, City or Town, State, Zip Code)
	parmit. Pagas 1 and 2 should be filad within Department of Health and Mental Hygiane. Important: if Item 27 is marked other than may Injury or other traumatic event, the Manace. To Be Compl	VICTORIA GRAY /OAUGH		
ore	of He	20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State	Ob. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State
Ĕ	Pag nent int: If	4 □ Donation 5 □ Other (Specify)	RESTLAWN MEM. GAR	1/3/2004 MARRIOTTSVILLE, Md
Baltimore	parmit. Paga Department of Important: If eny Injury or once.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility	1ZUMBRUN EH& MON CO
m	Depa Impo eny Ir	I teffy N. Zumbrun		le Road Ezpensbung mo 21764
		23a. Pert1. Enter the disease, or complications that caused the		or respiratory arrest Appreximate
Mary Service	Physician Physician	shock, or heart failure. List only one cause on each line.		Interval Between Onset and Death
1	/Medical	Immediate Cause (Final	~	undi-
	Examiner	disease or condition resulting in death)	to for on a consequence of the	1 ture
			to (or as a consequence of):	last the
٥.	executed in and ial-transit	b. Cultural Disease	to (or es a consequence,of):	Cinc.
7	n and ial-tra	if eny, leeding to immediate	Alst P	0 1
68760,	2 <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u> <u>1</u>	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated evenits	to (or as e consequence of):	almonny Oran 254
.89	entificate be aling physicia se as the bur	resulting in death) Last	to (or as a consequence or).	/
×	certification and ing			
Bo	atter		this is the underlying source share in Cost I	23b. Did tobacco use contribute to the cause of death?
0	the d	Part II. Other significant conditions contributing to death but no	or resulting in the underlying cause given in Part I.	
Δ.	es that the daath c gned by the attend be datached for us by Physician			1 XYes 2 No 3 Probably 4 Unknown
Records,	8 5 6			24a. Wes an autopsy 24b. Were autopsy findings
Š	been shou			performed? available prior to completion of cause
ec ec	% & &			of deeth?
	The cate h page			1 ☐ Yes 2 🕅 No 1 ☐ Yes 2 ☐ No
of Vital	Physician: The is this cartificate har ral director, page: To Be Com	25. Wes case referred to medical examiner?	Othor	ath (Check only one)
5	Physical this call direction To		2 EN Outpetient 3 DOA 4 A Nursing H	ome 5 Residence 6 Other (Specify)
	ng P	27. Manner of Death 1 ⚠Naturel 5 ☐ Pending (Month, Dey Yea		28d. Describe how injury occurred
Sio	Attending in death. Sctor: After by the fune file at lor.	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	
Division	tal or Attending Pins after death. al Director: After tiled in by the funera Certification:	4 Homicide determined 28e. Place of Injury - building, etc. (S)	At home, farm, street, factory, office pecify)	28f. Location (Street end Number or Rurel Route Number, City or Town, State)
Ω	rat o			
	To the Hospital or Attending Phy within 24 hours aftar death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:]	29a. Certifier 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner.	y knowledge, death occurred et the time, date and place mination end/or investigation, in my opinion, death occu	, and due to the cause(s) and manner as stated. rred at the time, date and place, and due to the cause(s)
	thin 2, the Formplet		29c. License number	29d. Date signed (Month, Dey, Year)
	CO T WITH	29b. Signafule end title of certifier	A COLLAND	250. Date signous production, Dey, Tear)
J	, i	Jum / Mille	m 123443	11/1/2004
	2+1	30. Name end eddress of person who completed cause of deeth	(Item 23e) (Type, Print)	Westminster, MD21157
	0	John W. Middleton	1 688 POOLE Koud	Westminster, VN D21157
	State	31. Deterfiled (Month, Day, Year) 32. Registrer's S	signature A La	•

State of Maryland / Department of Health and Mental Hygien 2004

		•	For State Registrar	olato or marytane	Ce	rtificate of	Death		leg. No.	U 4	349	18
	Physicia	3n	1. Decedent's Name (First, Middle, Las				21114	2. Date of Dea		~ Xear	3. Time of	
1	/Medic			WARD			GUM	0℃TÖBER			6:25	Рм
	Examin	er	4a. Facility Name (If not institution, give SINAI HOSPITAL	street and number)		E	BALTIMORE		4c. Coun	ty of Death	N/A	
	Funeral Director		221 00 0003	7. Age (In yrs. Ia	st birthday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day	1915	9. Birthp Cour	place (State or htry)	_
	he Maryland 8a-f show withed at	Director	Usual Rasidence of Decedent 10a. State 10b. County MD BA 10e. Street and Number	ALTIMORE 10c. City.	Town or Lo		BALTIMORE				0d. Inside Cit	•
	th with t	ai Dir	2401 WILLOW GLEN	DRIVE		10f. Zip Code	21209		log. Citizen of	what Cour	USA	
Baltimore, Maryland 21215-0036	72 hours after death with the Maryland "natural", or items 23e or 28e-f show idical Exercities from the notified at	d by Funerai	11. Marital Status 1 □ Never Married 2 🛣 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		1 □ Yes 2 🌠 No		ecify Yes or No- Rican, etc.)	14. Ra Bla Speci	ace - Americ ack, White, ify:		
215-(- "	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of I	Business/In	dustry	
21	be filed within tal Hygiene. od other than event, the M	Com	Elementary/Secondary (0-12)	55.15g5 (1.46.161)	PROP	RIETOR	T		RETAIL		OR STO	RE
and	ihould be filed withir id Mental Hygiene. marked other than matic event, the M	To Be	17. Father's Name (First, Middle, Last) JEROME		LEGU	М	18. Mother's Name	e (First, Middle, i	Maiden Suma	ime)	DUBIC	К
Mary	a sa	-	19a. Informant's Name/Relationship (7	ype, Print)			and Number or Rura				Code)	
ē, N	s 1 and 2 of Health item 27 I		IDA LEGUM / WIFE 20a. Method of Disposition		ace of Dispo	WILLUW GI esition (Name of matory or other place	LEN DRIVE	-	MURE, 20c. Location			
imo	0 0		1 💢 Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify		WITZ	NUSACH AF	RI(NER TAN	MID)		EDALE	•	
Balt	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licen	antten			ess of Facility SOL TERSTOWN					80
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.			-	or respiratory arr	est,		Approximate Interval Betw Onset and D	veen
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	a		RDIAL IN	FARCTION				1 MIN.	
	Examiner	1	Sequentially list conditions,	b. Due to (or as a consequ	ence of):			-				
	cuted nd ransit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c								
68760,	death certificate be executed e attending physician and nd for use as the burial-transit		resulting in death) Last	Due to (or as a consequence)	ence of):							
89	artificating physes as the	Medical	IF FEMALE:									
.O. Box	at the death cert by the attendinatached for use	Physician/I	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnan 1 ☐ Live birth 2 ☐ Fetal of the pregnant at time of decent of the program of the pregnant at time of decent of the pregnant at time of decent of the pregnant at time of the pregnant at time of the pregnant at time of the pregnant of the	death 3[Ectopic pregnanc Other (specify)	у		T .	ate of delive lanth	•	ear
S, P	as tha	by	Part II. Other significant conditions of	ontributing to death but not resul	lting in the u	nderlying cause giv	ven in Part I.		bacco use cor			
corc	w require been si should I	ieted						1 ☐ Ye	Λ.		ably 4 □Ui psy findings a	
of Vital Record		Completed						autops		prior to condeath?	πpletion of ca 2 X No	use of
Vita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Death					
		: To	1 ☐ Yes 2 💢 No 27. Manner of Death	28a. Date of Injury	R/Outpatier 28b. Time o	11 3L DOA		me 5 Reside			/)	
ion	Attending r death. ector: After by the funer	atior	1 ⚠ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury		rk?]Yes 2□No		. ,			
Division	i Qir	Certification	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (St City or Town		ber or Rura	l Route Numb	er,
_	Hospita 4 hours Funeral ely filled	edicai	29a. Certifier (Check only one) 1	ysician: To the best of my know iner: On the basis of examinati and manner stated.	vledge, deat on and/or in	h occurred at the til vestigation, in my o	me, date and place, opinion, death occurr	ed at the time, d	ate and place	, and due to	the cause(s)	
·	To the within 2.	Σ Y	29b. Signature and title of certifier	Ate		29c. Licens	D51426	2	9d. Date signe NOVEM		Day, Year) , 2004	
1	3-11×		30. Name and address of person who c				D - PIKES	VILLE. N	MD 2120	18		
~-925	Sta	_	31. Date filed (Month, Day, Year)	32. Registrar's Signatu		Spark						
	Registr	ar	NOV 0 4 2004	Serva ,	10 /	aprices						

State of Maryland / Department of Health and Mental Hygiene 🎧 🗓 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death **Physician** Mary Iris Martin 7:30 Рм October 31, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Dec. 23, Birthplace (State or Foreign Country) **Funeral** Days Hours 1933 West Virginia 1 ☐ M 2 🛣 F 70 Director 234-54-3198 Usual Residence of Decedent 10c. City. Town or Location show 10a, State 10b. County 10d. Inside City Limits The Medical Exeminer must be notified at 1 ☐ Yes 2 No Director Maryland Silver Spring Montgomery or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20906 Itame 23a 14007 Layhill Road United States filed withIn 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☑ No Specify: Specify: White \$ 3 □ Widowed 4 □ Divorced "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Laboratory Technician Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pagas 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked othe any liquy or other traumatic event 2008. Be Ray Martin Anna Bullough 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Dean/Sister 2714 Weller Road, Silver Spring, Maryland 20906 20b. Place of Disposition /Name of Date 20a. Method of Disposition 20c. Location - City or Town, State November 6, cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Philippi, West Virginia Mt. Vernon Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 2004 Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 21. Signature of Funeral Service Licensee 23a. Part1. Emper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) days Physician Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy þ in the past 12 months? 1 ☐ Yes 2 ☒ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Congestive Heart Failure, Chronic Obstructive 1 Tes 2 No 3 Probably 4 Unknown Completed Pulmonary Disease, Atrial Fibrillation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No certificate has autopsy perform Diabetes Mellitus 2X No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No ဥ 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Hospitel or Attending 5 Pending 1 XNatural after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dato and place, and due to the cause(s) and manner stated. within 24 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dr. Lilvie Himz - Tomaloric 17500 58542 November 2, 2004 \mathcal{T}_{\cdot} 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Libuse Heinz-Momcilovic, M.D. 11501 Georgia Avenue, Wheaton, Maryland 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 0 4 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 2004 34920 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anna M. Moran 27, October 2004 7:14 PM^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 💢 F 90 029-01-8571 Director June 19, 1914 Massachusetts Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be inclined at 10d. Inside City Limits MD Baltimore Timonium 1 ☐ Yes 2√ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2300 Dulaney Valley Road 21093 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 Yes 2 No Specify: ģ Specify: white 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene, important: if item 27 is marked other than "na any injury or other traumatic event and once." College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Michael Joseph Mullen Hannah Hickey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Moran/daughter 1330 Gooseneck Road Baltimore, MD 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wad 22. Name and Address of Facility Director State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street nan or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a PARKINSON'S DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-transit certificate be executed the attending physician and Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2₩ No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1.-1)43721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIO MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) State NOV 0 4 2004

Registrar

OCTOBER 27, 2004

ANNA MORAN

			1 - For State Registrar	State of M	aryland	/ Depa	artment of H	lealth ai Death	nd Men		ien e g. No.	004	34921
Ī	Physici	an	1. Decedent's Name (First, Middle, I							Date of Deatl Month	h Day	Year	3. Time of Death
1	/Medic	al	MARY L	MACK			# 6% T-	.1		CTOBER		2004	10:20 PM
	Examin	ier	4a. Facility Name (If not institution, g		CON	Ma	4b. City, Town, or				4c. Co	ounty of Death	
	Funeral			7	e (In yrs. Ia:		If Under 1 Year	If Under 2	4 Hrs. 8. r	Date of Birth	1	9. Birth	place (State or Foreign
	Director		213-36-2331	1□M 2∰F	65	Yrs.	Months Days	Hours	Min.	Month, Day, 1-10-1	938	Cou	yland
	pur &		Usual Residence of Decedent 10a, State 10b, County		10c City	Town or Lo	cation						10d. Inside City Limits
	Maryla f sho	ō											1 Yes 2 No
	28e-	Director	Md N/A 10e. Street and Number		Balt	imore	10f. Zip Code			10	og. Citize	n of What Cou	intry?
	h with		701 Deacon Hill	Court			21225				U.S.	Α.	
	ems a	Funeral	11, Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13.	Was Decedent of H	ispanic Origi	in? (Specify	Yes or No-	14.	Race - Ameri Black, White	
36	s after	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 2			1 ☐ Yes 2 No	Specify:		.,,	St	pecify: Blac	
Ö	72 hours after death with the Maryland Ineturel, or Items 23e or 28e-f show died Exertirer must be notified at		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's	Year or Dates:		16a Dece	dent's Usual Occup	ation				of Business/Ir	
5.	S 38	Completed	(Specify only highest s	grade completed)		(Give	kind of work done of DO NOT use retired	during most o	of working		IOD, KIIIU	Or Business/ir	loustry
212	filed within 7. Hygiene. other then "n	E O	12	College (1-4or	0+)	De	li. Clerl	ĸ			Food		
nd	be filed tal Hygid of other event.	Be (17. Father's Name (First, Middle, La	st)						st, Middle, M		ımame)	
yla		၉	James Camp					- -		se Nea			
Maryland 21215-0036	d 2 h a 2 h a 4 h		19a. Informant's Name/Relationship Virgil Mack 3rd				ng Address (Street a						o Code) 11and 21215
	feall	1	20a. Method of Disposition		20b. Pla		sition (Name of matory or other place		Date	_		tion - City or T	
lon	ages ant of it: If it		1 Burial 2 Cremation 3		1	netery, crer Cathe			0/29/3	100			aryland
Baltimore,	permit. Pages Department of H Importent: If ite any injury or ot		21. Signature of Funeral Service Lig		ITCW		2. Name and Address						
ñ	Der Imp		+ CLASEL	ue		70	O S. Beed	chfiel	d Ave	Balt	imor	e, Mary	land 21229
	- R		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused ly one cause on each li	the death.	Do not ent	er the mode of dyin	g, such as ca	ardiac or res	spiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	RENAU	FA	LURE	E						Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as				_					
н	LAGITIMICI	-	Sequentially list conditions	b METAS Due to (or as			on CANC	ER					3 months
/	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 (0 (0. 40	2 001100000	1100 01).							
,	s be executed sician and burial-fransit	Еха	that initiated events resulting in death) Last	C. Due to (or as	a conseque	nce of):							
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	dlcal		d									
9	intifica ing ph a as th	Med	IF FEMALE:								-		
Вох	death certific attending pl	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	2 Fetal d	eath 3	Ectopic pregnancy				230	I. Date of deliv Month	ery Day Year
0.	the a	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant ai 9⊡ Unknown	time of dea	ith 5∐	Other (specify)						
۵.	requires that the d een signed by the hould be detached		Part II. Other significant conditions	contributing to death b	ut not result	ing in the u	nderlying cause give	en in Part I.		23e. Did tob	acco use	contribute to t	he cause of death?
rds,	quires n sign ald be	d by	HYPERTERSION							1 ☐ Ye	s 2 1 82[1	lo 3 ☐ Prol	oably 4 Unknown
CO	aw requir as been si 2 should	ompleted	DIABETES ME	LLITUS						24a. Was an		24b. Were auto	opsy findings available
R	e ye	mo								autopsy perform 1 ☐ Yes 2		prior to co death? 1 🗌 Yes	mpletion of cause of
ta	icien: Th certificate ector, pag	Be C	25. Was case referred to medical examiner?					26. Place o		eck only one			
of Vital Record	Physicien: this certific ral director,	٩	1 □ Yes 2 □ No		ent 2 El			4 INUIS				Other (Specia	(y)
	ing After une	lon:	27. Manner of Death 1 ♣Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year) 2	8b. Time of Injury	Work			Describe how	w injury o	ccurred	
Division	ead or:	licat	2 Accident investigat 3 Suicide 6 Could not	ho -	urv - At hom	e. farm. str.		Yes 2□No		ocation /Str	eet and N	lumber or Rur	al Route Number,
Ď	Dir	Certification:	4 Homicide determine	building, et	c. (Specify)	9, 101111, 011	eet, factory, office			City or Town,			arriosic resinoci,
	spite ours serel fille		29a. Certifier 1 Certifying	Physicien: To the best	of my knowl	edge, death	occurred at the time	ne, date and	place, and c	lue to the ca	use(s) an	d manner as s	tated.
	To the Hos within 24 h To the Fur completely	edical	(Check only 2 Medicel Ex	aminer: On the basis o and manner st	t examinatio ated.	n and/or in	vestigation, in my op	oinion, death	occurred at	the time, da	te and pla	ace, and due to	o the cause(s)
L e_	To the k within 24 To the f	Σ	29b. Signature and title of certifier	050	1		29c. License		1 -			igned (Month,	
•	1		1	benten	w			176	40		O CTO	BER 2	5,2004
	9		30. Name and address of pelson wh				•		1 ,	. 0 -		- 10	
	- Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signatu	9 S	GREENE	- 150	TCIM	over/	40	2120	1
	Registr		NOV 0 4 200	Steeler	K,	free	E .						

State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Lest) 2. Date of Deeth Month **Physician** 1030AN 2004 2 10 /Medical 4b. City, Town, or Location of Death 4e. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ella GIIGBelainRd BACTIMORE CIT 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 7 F -36-401-65 Director /*93*8 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylend Depertment of Health end Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be nothed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits BALTIMORE Director BALTIMORE CIT 1 Yes 2 No 10f. Zip Code 10g. Citizen of Whet Country? 21206 USA Colllo Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. \$ 4 Divorced 3 Widowed Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) office manager 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Otto Bussenuis 2 Valma Riston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Nancy Witzel/cousin 3207 Westfield Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signature of Fumeral Service Licensee ROnald S. Wade, Director vom Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Colon with Metastasis /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificete be exacuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause | Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the dearn within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 🗆 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1 Natural

2 Accident 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Dey, Year) 10-30-2004 1au N Blud, Bultimore MD 21239. 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 5601-Loch Kaven 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

DHMH 16 Rev 6/95

			1 - For State Registrar	- 1	ryland / Depa Cei		ealth and M	lental Hy	_	
	Physici /Medic		Decedent's Name (First, Middle, La Nathan R	eingold				2. Date of Dea	Day Ye	4 10:57A M
	Examin	er	4a. Facility Name (If not institution, given 5305 Glenwood Roses Social Security Number 6.5	ad	(In yrs. last birthday)	4b. City, Town, or Bethesda If Under 1 Year		8. Date of Birt	4c. County of D	ery
	Funeral Director		103-20-1572 Usual Residence of Decedent	X M 2□F	77 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da) March 23	y, Year) 3, 1927	Birthplace (State or Foreign Country) New York
	Ba-f show	ector	10a. State 10b. County Maryland Montgo	omery	10c. City, Town or Lo	ethesda				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23a or 2	rai Dir	10e. Street and Number 5305 Glenwood Ro	ad		10f. Zip Code 208			United S	-
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "netural", or Itams 23a or 28a-f show any Injury or other traumetic event. Its Madical Exalt har must be maillised at ance.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2 ☑ No		Rican, etc.)	Black, W	white, etc. White
1215-0	vithin 72 ho ne. han "netu	Completed	15. Decedent's E (Specify only highest gri Elementary/Secondary (0-12)	ade completed) College (1-4or 5-	16a. Dece (Give life.	dent's Usual Occupa kind of work done di DO NOT use retired)			16b. Kind of Busine	
Maryland 21215-0036	12 should be filed within " h and Mental Hygiene. 7 Is markad other than "! Iraumatic event, Ita Med	Be	17. Father's Name (First, Middle, Last			Histor	18. Mother's Name		Maiden Sumame)	rganization
	nd 2 should alth and Me 27 Is mark	To	Benjamin Reingolo 19a. Informant's Name/Relationship (Ellen G. Miles /	Туре, Print)	1		nd Number or Rura	I Route Numbe	or, City or Town, State Maryland	
Baltimore,	Pages 1 annout of Heamant: If item		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		20b. Place of Dispo cemetery, crea Montgomer Cremato	osition (Name of matory or other place y orium, Inc	Novem	ober 2	20c. Location - City Bethesda,	or Town, State Maryland
Balt	permit. Departi Import any Inj		21. Signature of Fur eral Service Lice	Ero MC	1200 D6	etnesda, M	lary Land	20814-3	501	Tuneral Home/ onsin Avenua
	Physician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aAspirat	ion Pneumo		, such as cardiac c	or respiratory ar	rest,	Approximate Interval Between Onset and Death 3Days
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Cerebro	consequence of): vascular A consequence of):	Accident				8 Days
0,	be executed ician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a	consequence of):					
c 68760,	certificate be Iding physici Ise as the bu	Medical	IF FEMALE:	d						
.О. Вох	death e atter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 1 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year
Δ.	sign d be	ed by PI	Part II. Other significant conditions Valvular Heart I		t not resulting in the u	nderlying cause give	n in Part I.			e to the cause of death? Probably 4 □Unknown
Il Records,	The law ate has b page 2 st	Completed by							sy prior med? death	autopsy findings available to completion of cause of ? es 2 No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ⅓No	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatier	othe.	26. Place of Death			
ion of	fter nei	ation: To	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	28b. Time o	f 28c. Injury Work	at 2		lence 6 Other (S low injury occurred	рөспу)
Division	To the Hospital or Attending I within 24 hours after death. To the Funaral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined		ry - At home, farm, str . (Specify)	reet, factory, office	4	28f. Location (S City or Tow	Street and Number or n, State)	Rural Route Number,
	he Hosp n 24 hou he Funa pletely fil	edical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the d ed at the time, d	cause(s) and manner date and place, and o	as stated. due to the cause(s)
	To the To the Complex of the Complex	Σ	29b. Signature and title of certifier	400	4. 0	29c. License			29d. Date signed (Mo	
	15		30. Name and address of person who Brent K. Cole, M			•			November Maryland	
	Sta Registi		31. Date filed (Month, Day, Year) NOV 0 4 2	32. Registra	r's Signature	box				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend tatte of Marytand PBEpattment of Health and Mental Hygien 2 0 0 4 34924 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year NOVEMBER 2, 2004 **Physician** ALICE HESTER RICH 10:10pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** MANOR CARE RUXTON TOWSON BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign
 Washing) **Funeral** Months 1 M X XF 220-14-0765 Yrs Director 85 1919 WEST Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 28a-f show 10a. State BALTIMORE TOWSON 1 ☐ Yes X No MD Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23e or 2 800 SOUTHERLY ROAD 21286 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes XXNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1

Never Married 2

Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) LIBRARIAN LIBRARIAN marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be finent of Health and Mental I ERNEST ALBERT RICH ALICE OLIVER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HUNTER RICH 425 BROOKMONT LN. N.BARRINGTON, ILL. 60010 nephew Health Item 27 other tre 20b. Place of Disposition (Name of cemetery, crematory or other place) 20b. Place of Disposition (Name of cemetery, crematory or other place)

ALL SAINTS CEM. NOVEMBER 2004 EISTERS TOWN, MD. 20c. Location - City or Town, State 20a. Method of Disposition 5 = 5 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. ervice Licensee 16924 YORK RD. MONKTON, MD. 21111 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on sach line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the Hospitel or Attending Physicien: The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Box 68760, physician the burial Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has be irector, page 2 s 2. No 1 Yes 25. Was case referred to medical examiner? Be (26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 his Manner of Death
Natural
Accident 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No after death | Director: / d in by the f 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funerel C completely filled i ix Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) D-0012849

State Registrar

31. Date filed (Month, Day, Year)

AH. GHILA.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1111.

OSLER Dr. TOWSON MD 21204 7600

State of Maryland / Department of Health and Mental Hygier 10 14 34925 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** ouise 0530 October 28 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4h City Town or Location of Death Examiner of Medical Center Maryland Baltimore University If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 78 1 □ M 2√□ F Director Oct 2, 216-22-0929 Usual Residence of Decedent 1926 Ohio 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Prince Georges Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15611 Haynes Road 20707 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No ģ SpecifyWhite 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Owned Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Neva Peede Roy Adkins 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Rich/Husband 15611 Haynes Rd. Laurel, Md 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 11-01-04 Ft. Meade, Md 22. Name and Address of Facility Fleck Funeral Home, Inc. Signature of Tuneral Service Line, nsee once. emya Juliut 7601 Sandy Spring Rd. Laurel, Md 20707 23a. Part1. Enter the Jise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart filture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis /Medical Due to (or as a consequence of) Examiner and Gasto intestinal Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner hocytic Lenkemia or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 5 ☐ Other (specify) 4□Pregnant at time of death 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕍 ☐ nknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 € No 24a. Was an autopsy performe this certificate 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Inpatient 0 1 Yes 2XNo 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA the funeral 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After t 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Diractor: 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 35F15270 Fox me and address of person who completed cause of death (Item 23a) (Type, Print) strethan 32. Registrar's Signature NOV 0 4 31. Date filed (Month State

Registrar

State of Maryland / Department of Health and Mental Hygie (Pen) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year RIZOR 5:35 PM 10 2004 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** of Mayland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Dec. 25, 1. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1X M 2□ F Months 098-38-1327 Oregon Director Usual Residence of Decedent 10b. County 10c. City, Town or Location worls. 10d. Inside City Limits nem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be notified at Yes 2□No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3611 Violetwood Place 20715 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Heelth and Mental Hygiene. Interval: If Item 27 is marked other than "natural", or Item any injury or other traumetic event. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify:White 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Arthur Rizor Jr. Nancy May Delores Pugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeeDee Rizor/wife 3611 Violetwood Place Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State W. Arundel Crematory 4 ☐ Donation 5 ☐ Other (Specify) 4, 2004 Odenton, Maryland 21. Signature of Funeral Service, Going Home Cremation Service P.O. Box 784 Bevu MO1251 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aortic dissection **Physician** 22 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Year Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. certificate 1 🗌 Yes 2 🗶 To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death

Natural

Accident ate of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After s after dec. 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 225 6 run Purch Smeet AUNTE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 4 2004 Registrar

			State of Maryland / Department	artment of Health and M ####################################	ental Hygie		7
	Physici	an	1. Decedent's Name (First, Middle, Last) HELMUT RIEHL	0.7704	2. Date of Death Month	Day Year 3. Time of Dea	
	/Medio		4a. Fecility Name (If not institution, give street and number) JH PAYVIEW MED. CTR.	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 219 55 1409 197M 2□F 6 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea July 27,1	ar) 9. Birthplace (State or For Country) 943 Germany	reign
	h the Maryland r 28a-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo WEST 10e. Street and Number	ninster	10g.	10d. Inside City Li 1 XYes 2	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. I Health and Mental Hygiene. I then 12 Is marked other than "netural", or Items 23e or 28a-f show other treumatic event. The Madical Examerer must be rotified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	A 115 8 Was Decedent of Hispanic Origin? (Spet Yes, specify Cuban, Mexican, Puerto II ☐ Yes 2 № No Specify:	16b.	14. Race - American Indian, Black, White, etc. Specify: White Kind of Business/Industry	
	filed within 7. Hygiene. other than "n ent, the Medi	e Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. L	kind of work done during most of working OO NOT use retired) HANT MARINER 18. Mother's Name	ng	erman NAVY	
Maryland	should be ind Mental marked c	To Be	LAMBERT Right 19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	Teonie g Address (Street and Number or Rura		ARTEN	
Baltimore, Ma	0 0		HANNELONE L. Richl / WIFE 20a. Method of Disposition 1 Burial 2 Micromation 3 Removal from State 4 Donation 5 Other (Specify)	CROSSBRINGE DRI sition (Name of natory or other place) WIL CREM. 11/4/2	ve west, ate 20c.	ninster mo 211. Location · City or Town, State in field, mo	28
Balt	permit. Pag Department Important: I any injury o		Jeffy V. Jumbrun 60		and ELDE	=1+ & MON CO 1564RG-MO 2178	4
MIN STATE	Pnysi cia n /Medical Examiner	ner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, large leaves. Enter Underlying	°E	respiratory arrest,	Approximate Interval Batweer Onset and Deat	h h
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edical Examiner	Cause (Disease of initing	ATION			
О. Вох	at the death certific by the attending p tached for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the un DIABETES MELLITUS, CONCEST		23e. Did tobacco	ouse contribute to the cause of death	
al Reco		Completed	FAILURE, HYPERTENSION		24a. Was an autopsy performed?		able of
Division of Vital Records,	ding Physiclan: Th h. After this certificate funeral director, pag	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation			6 □Other (Specify) jury occurred	
Divisi	Hospitel or Attending 4 hours after death. Funeral Director: Afte tely filled in by the fune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, stre building, etc. (Specify)		8f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)	
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fun	edicai C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medicel Exeminer: On the basis of examination and/or invand manner stated.	occurred at the time, date and place, an estigation, in my opinion, death occurre	nd due to the cause(d at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)	
•	To the within comp	Me	29b. Signature and title of certifier MD	29c. License number 23014		Pate signed (Month, Day, Year)	
	J.		30. Name and address of person who completed cause of death (Item 23a) (Type, F JH BAYVIEW MEDICAL CENT	Print)			
	Sta Registr			Souls			

of this in black illuctible lik. Elisule	All Copies Are Legible.	
of Maryland / Department of Health and Certificate of Death	Mental Hygien 0 0 4	34928
	2. Date of Death	3. Time of Death

1			1 - For State Registrar		State of	Marylan	id / Depa <i>Cei</i>	irtment <i>tificate</i>	of H	ealth a D <i>eath</i>	nd IV	lental Hy	/gien £ Reg. N) 4	34928
	Physici /Medic		Decedent's Nam Mohamm		-							2. Date of D	eath		004	3. Time of Death 9:54 A M
7	Examin		4a. Facility Name (14100 blk		n, give street and num	iber)		4b. City, T		Location of	Death		4	CEC	of Death)
	Funeral Director		5. Social Security N 089-84-8	784	6. Sex X M 2 □ F	7. Age (In yrs. 27	- 1	If Under 1 Months	Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Bi (Month, D May 20	rth ay, Year)	9. Birth	place (State or Foreign http://
	the Maryland 28a-f show	tor	Usual Residence of 10a. State	10b. County	ssex	10c. Cit	y, Town or Lo	cation	N	lewark		-				10d. Inside City Limits TAXYes 2 ☐ No
	th with the 23a or 28a ust be noti	rai Director	10e. Street and Nu					10f. Zip (107			10g. C	itizen of V	Vhat Cou	·
36	rurs after death with the Man el', or Itams 23a or 28a-f sh Examiner must be muiffed	by Funerai	11. Marital Status 1 Never Marr 3 Widowed		If Yes Give	ces? 2]X]K lo 9	l t	Vas Decede Yes, specif		spanic Origi n, Mexican, Specify:	in? (Spe Puerto	ecify Yes or N Rican, etc.)	0-		k, White,	can Indian, etc. white
Maryland 21215-0036	ba filed within 72 hours after death with the Maryland tal Pyglene d other than "neturel", or Itams 23a or 28a-f show event, the Madical Examiner must be mailled a	Completed	Elementary/Seco	cify only highe	t's Education st grade completed) College (1-	4or 5+)	16a. Deced (Give life. L	ent's Usual kind of work OO NOT use	Occupa done di retired)	ition uring most o	of worki	ng	16b. l	Kind of Bu		_
and 21	s 1 and 2 should be filed within 72 ho I Health and Mental Hygiene. Item 27 is marked other than "netur other traumatic event, The McGGGAL	To Be Cor	8 17. Father's Name Mohammed		_	•		Manag	er	18. Mother		(First, Middle	a, Maidei	n Sumam	Food e) Uhk.	
	nd 2 should atth and Men 27 is marka		19a. Informant's N		hip <i>(Type, Print)</i> iyani / Cousi	in				nd Number	or Rura	I Route Numb	per, City	or Town,		
Baltimore,	parmit. Pages 1 and 2 Department of Health a Importent: If item 27 i any injury or othar tre ance.		20a. Method of Dis 1 Burial 2 4 Donation		3 🔀 👣 noval from S	tatec	Place of Disposemetery, crem	sition (Name atory or oth	of er place			ate	_	ocation -	City or To	own, State
Balt	parmit. Departr Importe any inji		21. Signature of Fu	ineral Service	Licensee Victor	P. Doda,	U.	Name and Bries I	Address Sta	s of Facility EVENS I	uner e. F	al HOme, altimore	Inc	• 21.220		
	Physician		shock, or hea Immediate Cause disease or condition	irt tailure. List (Final	complications that ca only one cause on ea	used the reath	n. Do not ente	or the mode	of dying	, such as ca	ardiac o	r respiratory a	irrest,	61230	li li	Approximate Interval Between Onset and Death
	/Medical Examiner	h	Sequentially list co	nditions,	b. ———	r as a consequ			,							
VI	be exect fed ician and burial-transit	Examiner	cause. Enter Under Cause (Disease or that initiated events resulting in death)	erlying injury s	c	r as a consequ										
68760	tificate be e. ng physician as the buria				d.								_			
P.O. Box 68760,	quires that the death certificate be executed in signed by the attending physician and uld be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceden in the past 12 1 Yes 2 [9 Unknown	months? ☐ No		th 2 🗍 Fetal nt at time of de	death 3	Ectopic prec Other (spec						23d. Date Mon		ory Day Year
rds, P	quires that en signed b uld be deta	ed by PI	Part II. Other signif	ficant condition	ons contributing to dea	ith but not resu	ulting in the un	derlying cau	ıse giver	n in Part I.		23e. Did 1		N		e cause of death?

Division of Vital Reco bae To the Hospital or Attending Physicien: The law re Complet Be this After thi Certification: within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

to the cause of death? Probably 4 Unknown

24a. Was an 1 Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Hother (Specify)

28 Describe how injury occurred

1 Natural 5 Pending investigation 2 ccident 3 Suicide 6 Could not be determined At home, farm, street, factory, office 4 Homicide

28c. Injury at Work? 1 🗌 Yes

OCME

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 29b. Signature

25. Was case referred to medical examiner?
1 X Yes 2 □ No

27. Manner of Death

29c. License number

29d. Date signed (Month, Day, Year) NOVEMBER 3, 2004

30. N

111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, I

1 Inpatient 2 ER/Outpatient

3□ DOA

State of Maryland / Department of Health and Mental Hygiens 1 - For Stete Registrer Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 10:30 Pm. м Ada Sanders Nov 1, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore N/A 2707 Lauretta Ave 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min.

8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 SC. 1 M 3 F Director Yrs. 249-40-5493 83 Jul 15, 1921 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23a or 28a-f ehor treumetic event, the Mudical Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2707 Lauretta Ave. 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Rentex Co. **Employee** 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Elizabeth Edmond John Edmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Janice Pearson 2707 Lauretta Ave. Baltimore, Maryland 21223 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 D Burial 2 Cremation 3 Removal from State permit. Page Department of Importent: If any injury or once. 11/08/04 Baltimore, Md. * 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit attending physician and Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 mor Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Endo conta ha Completed 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 2 No 2 🗆 No 1□ Yes 1 🗆 Yes : After this certifica e funeral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Tyes 2 10 Other: Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 4 Nursing Home 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending I Director: A d in by the fr 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after To the Funeral Direc 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical completely (Check ont the 29b. Signatur and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) 31 30. Name an addr ss of person who completed cause of death (Item 23a) (Type, Print) BALTINORE M 21202 MESHOUM 301 #COT 31. Date filed (Month, Day, Year) 32. pegistrar's Signature NOV 0 4 2004 Registrar

04-7010 B.K.S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

CARRIE J. SPANGLER II State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year SPANGLER II **Physician** JOYCE OCT 1436 P ^M 30,_ 2004 /Medical y Name (If not institution, give street and number)
WILLOWDALE DRIVE #44 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth , (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours Min 1□M 2XF 925 60 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Item 27 is marked other then "natural", or Itams 23a or 28a-f show other treumatic event, Ite Mydical Exacting or natibe multied at 1 Yes 2 □ No Completed by Funeral Director PENERICK FRENERICK MY 10g. Citizen of What Country? 10e. Street and Number USA WILLOWDALE DRIVE APT44 21702 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☑ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If Item 27 Is marked other then College (1-4or 5+) Elementary/Secondary (0-12) COSMETICS COSMETOLOGIST 0 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be CARRIE Iliam ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WILLIAM C SPANGLER NR/BROTHER 2160 MORNINGWIND DR MARRIOTTSVILLE MO 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State 5 12004 MEADOWRINGE Mein PK! 111 ELKRINGE, MO 4 Donation 5 Other (Specify) 22. Name and Address of Facility JN ZUMBRWN FIT & MON Co 21. Signature of Funeral Service Licensee 6028 SYKESVILLE ROAD ELDENSBURG-MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** hvanic ALCOHOLISM /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Day in the past 12 months? Month signed by the atte 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown Chronic obstructive 1 Yes 2 🗆 No Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No page 2 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE 1 X Yes 2 □ No 10 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred funeral 27. Manner of Death Certification: After Injury Hospitel or Attending 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No investigation death. Director: / 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide within 24 hours a To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifi O.C.M.E OCT. 31, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 M JACK MITITUS M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

	Ng.	1 State Registrar 1. Decedent's Name (First, Middle, Las	st)		rtificate of l		Reg 2. Date of Death		3. Time of Death
Physici /Medio			Charle	es Thoma	as		Month	Day Yeer DV 1, 2004	6:20 Pm. M
Examir		4a. Fecility Name (If not institution, give	e street and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	ш		t Haven Nursing				nsville	Balti	more
uneral irector		210-24-1094	ex 7. Age ((In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y- Apr 7, 1		olece (State or Foreign otry) Pa.
Mo		Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation			1	0d. Inside City Limits
Hed h	ō	Maryland Ch	narles		V	Valdorf			1 ☐ Yes 2 No
a or 28s	Director	10e. Street and Number 3507 Lisa Lane			10f. Zip Code	20601	10g	. Citizen of What Cour	-
ma 2	Funeral	11. Marital Status	12. Was Decedent Ev	er in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-	14. Race - Americ	ean Indian,
Important: If item 27 is marked other then "natural", or itema 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinat must be notified at once.	by Fu	1 ☐ Never Married 2 ☐ XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates:	1050	if Yes, specify Cuba 1 ☐ Yes 2 ☐ XNo		Hican, etc.)	Black, White, Specify:	_{etc.} Black
lical	ted	15. Decedent's Ed (Specify only highest gra		16a Dece	dent's Usual Occupa	ation	16	b. Kind of Business/Inc	dustry
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n, El		12 17. Father's Name (First, Middle, Last)			Contra	·	e (First, Middle, Mai	idon Sumama)	
itic eve	To Be		Thomas Sr.			io. Mother's Halli		Vinston Thoma	s
rtrauma		19a. Informant's Name/Relationship (7 Estella Thomas Wife	Type, Print)				ral Route Number, C laryland 20601	ity or Town, State, Zip	Code)
othe	3	20a. Method of Disposition		20b. Place of Dispo	and the second s			c. Location - City or To	wn, State
ıry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ • 4 ☐ Donation 5 ☐ Other (Specify	Luellionari Ironii State		Memorial Ga	1	11/05/04	Waldorf , N	Maryland
eny inju		21. Signature of Funeral Service Licen	see	22		Funeral Hom		144 00000	
i.		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused th	e death. Do not ent			ad Aquasco, I or respiratory arrest,		Approximate
ian	81 7	Immediate Cause (Final disease or condition	one cause on each line.	ASPIRA	ATTON	PNEUI	MONIA		Interval Between Onset and Death
ical		resutting in death)	a. Due to (or as a c	consequence of):					
ner		Sequentially list conditions.	b. —————						
io.	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underspiring Cause (Disease or injury that initiated events	Due to (or as a c	onsequence of):					
al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of):					
as the burial-transit	edical Examiner		ď						
as th	957	TETEL TANK	=					F-802	
detached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 [Ectopic pregnancy			23d. Date of delive	,
Deu	ysic	1 Yes 2 No	4□Pregnant at tim 9□Unknown	ne of death 5□	Other (specify)			Month	Day Year
Detai		Part II. Other significant conditions co	ontributing to death but r	not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc	co use contribute to the	e cause of death?
e	ed by	HIZHEIME	RS				1 🗆 Yes	_	ably 4 Unknown
Should	ompleted						24a. Was an	24b. Were autop	sy findings available
irector, page 2 s	mo						autopsy performed 1 ☐ Yes 2 ☑	? prior to com	pletion of cause of
ctor.	BeC	25. Was case referred to medical examiner?	- 1 - 1			26. Place of Deat	h (Check only one)	140	
al director,	ဥ	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	2 ER/Outpatien	t 3 DOA Othe	r: Nursing Ho	me 5 Residence	6 ☐Other (Specify)
funeral	lon:	27. Manu of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time of Injury	Work	? _	28d. Describe how in	njury occurred	
y the	ficat	2 Accident investigation 3 Suicide 6 Could not be		- At home farm str		es 2 No	28f Location (Street	and Number or Rural	Route Number
d in by	Certification:	4 Homicide determined	building, etc. (Specify)	eet, ractory, office		City or Town, St	are)	noute Number,
completely filled		29a. Certifier Certifying Phy (Check only 2 Medical Exem	ysician: To the best of n	ny knowledge, death	occurred at the time	e, date and place,	and due to the cause	e(s) and manner as sta	ited.
completely filled in by the funeral director, p	ledical		iner: On the basis of ex and manner stated	amination and/or inv	estigation, in my opi	inion, death occurr	ed at the time, date	and place, and due to	the cause(s)
Con	Σ	29b. Signature and title of certifier	Lalling	Na.	29c. License	number	29d.	Date signed (Month, D	Day, Year)
		Joseph		- Ser Nor				1704	
				200110					
		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type, I	Print) PARK	11/2/10	THE AN	E BAI	D. MIN

Registrar

State of Maryland / Department of Health and Mental Hygiene 004 34932 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 15:07 M OCTOBER 30 Carolyn Tift 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE ST- AGNES If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) July 12, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Min. Months 1 ☐ M 2 🂢 F 214-54-6148 54 Ĩ950 Georgia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore 1√2 Yes 2 □ No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1102 Wildwood Pkwy 21229 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ऒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1X Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: black Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) secretary legal 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked oth any injury or other traumatic event 9008. Be Robert Lee Tift Annie Maude Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sosha White/daughter 5114 Greenwich Avenue C12 Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Romald S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) BILATERAL PNEUMONIA **Physician** 4 DAYS /Medical Due to (or as a consequence of): LUNG (ANCER **Examiner** METASTATIC MONTATS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Dav 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes No No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√ No Certification: To 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 | Homicide within 24 hours at To the Funerel D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d, Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certifier 116693 OCTOBER, 30. AVENUE CATON 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SARUMI AGNES HOSPITM BALTIMORE 31. Date filed (Month, Day, Year) NOV 0 4 2004 2. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 004 34933 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** alth + Rehab. He Kc Year 's Kuxton If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign
 ACquintry) **Funeral** Days Hours 22-Min 10 M 20 F Director Yrs Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified a Maryland Be Completed by Funeral Director 1 XYes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a d 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 Divorced Slac "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a, Informant's Name/Relationship (Type, Print) (dayghter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/228 t of Health : ille 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State ò 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department of Importent: If eny injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home Md. Balto. th Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ALDIOMYUPATHY SCHAEMIC **Physician** /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Oner significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? AICURE 1 ☐ Yes 2 🗌 No 3 Probably MELLITUS ABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 2 100 1 Yes 2/2/No 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No 1 Inpatient As after dee... 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 4 Natural 5 Pending Injury 1 Yes 2 No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral L # Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 001 m) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)/ DACID MID 2/208 72 KITANI 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [] Registrary MEND ITEM #5 PER INF C837 1 Profit Pate Inf Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wadd Year Geor 2:25 AM Vovember /Medical Z004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Age (In yrs. last birthday) Year If Under 24 Birthplace (State or Foreign Qountry) **Funeral** Days Min 1**⊠**M 2□F Yrs. Director Usual Residence of Decedent the Maryland 10a State 10b. County Inside City Limits City, Town or Location Show other traumatic event, the Medical Examiner must be notified at 1 Kres 2 □ No timore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Itams 23a Completed by Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates: 3ack "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifp. DO NQT use retired) d 2 should be filed within 73 h and Mental Hygiene. 7 is marked other than "na dary (0-12) College (1-4or 5+) (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ese Name/Relationship (Type, Pri 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health an 20a. Method of Disposition Oc. Location - City or Town, State Pages 1 permit. Pages Department of Important: If It any injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee leur oad 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or re shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cerebra Vascular DAY /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. à Renal Discase 1 Yes 2XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 🗆 No 1 🗌 Yes 2 X No 1 TYAS Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 🗌 Yes 2 No 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 November 2004 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lounge, 600 North Wolfe street Fukudome, Johns Hopkins Hospital 110. Doctors Eugene Tower 31. Date filed (Month Pay, 32. Redistrar's Signature Baltimore, MD State Registrar

DHMH 17 Rev 1/2001

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	or 28	Funeral Director	10e. Street and Number				10f. Zip					10g. Citiz	en of Wha	t Count	ry?	
	ath w	lal	14200 Highwood Dr						850				ed S	tate	s	
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lan	d be ental kad o	To Be	John Allen Weiler						Eva			, maider c	ournaine)			
Maryland	is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. I have seen 23a or 28a-f show itam 27 is marked other than "natural", or Itams 23a or 28a-f show other traumatic event, I'te Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (T	ype, Print)		19b. Mailin	g Address	(Street a			l Route Numb	er, City or	Town, Sta	te, Zip (Code)	
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Baltimore,	Pages 1 nent of He int: If itan		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	20b. Pla	ace of Dispo metery, cren e of	natory or of	ne of ther place) N		ber 6,		ation - Cit	•		
Ë	t. Partmen		'4 □ Donation 5 ☑ Other (Specify,		Ma	iuso1ei	ım			200	14				g, Mary	
Bal	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or othar once.		22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rocky 300 West Montgomery Ave., Rockville, MD 23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.								kvi D 20	lle, In 850 – 2805	ic.			
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	19d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Either till durying Cause (Disease or injury	Due to (or as		1,000	5 727	2			S-27 77 10					
<u>,</u>	axecun n and al-trai	Exar	that initiated events resulting in death) Last	Due to (or as		VA ence of):	ULA	R	INF	ARE	TION			-		
8760,	rate be executed thysician and the burial-transit			d												
9	The law requires that the death certificate be executed the has been signed by the attending physician and oags 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE:													
Вох	death certifica attending ph	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 🗌 Fetal	death 3 🗆	Ectopic pre					23	d. Date of		y Yay Yea	ır
0	that the de ed by the a detached f	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of dea	ath 5□	Other (spe	ecify)					NOTES		ay rea	
٥	res that the igned by be detact		Part II. Other significant conditions co	ntributing to death bu	it not resul	ting in the un	derlying ca	use giver	n in Part I.		23e. Did to	obacco us	e contribu	te to the	cause of deap	jh?
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Vital Records,	law requii as been s 2 should	Completed									24a. Was		24b. Were	autops	y findings ava	ulable
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of	d is	은 -	1 Yes 2 No 27. Manner of Death	lospital: 1 Inpatie		R/Outpatient 28b. Time of			4 🗆 Nurs		ne 5 Resid			Specify)		
	Attanding Ph or death. actor: After th by the funeral	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	М	3c. Injury : Work? 1 □ Y	at es 2.⊟N		8d. Describe h	tow injury	occurred			
Division	I or Attandii after death. Diractor: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At hon	ne, farm, stre	et, factory,	office		2	8f. Location (5	Street and	Number o	r Rural F	Route Number	
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	To t To t	Σ	29b. Signature and title of certifier	_				License				29d. Date				
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	MXI		Robert Kirkcaldy					er D	rivo	Pos	kville	M = -	· · · 7 - · · ·	1 00	050	
	Sta	_	31. Date filed (Month, Day, Year)	32. Registra	r's Signatu	ire				KOC	vatite	, mar	утап	1 20	000	
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 004 34936 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Marie P. Wilk P^{M} October 30, 2004 2:48 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10638 Weymouth Street #4 Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Jan. 8, 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 □ M 2 🖾 F 028-28-1900 66 Vrs 1938 Jan. Director Massachusetts Usual Residence of Decedent the Maryland 10a, State 10c. City. Town or Location 10b. County 10d. Inside City Limits or 28a-f show other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10638 Weymouth Street #4 20814 United States Items 23a death 1 Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Yes 2 🔯 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 naturel', or 1 ☐ Yes 2 ☒ No Specify: White Specify: à 3 ☐ Widowed 4 13 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than eny injury or other treumation. College (1-4or 5+) Elementary/Secondary (0-12) Business Machines Systems Analyst 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Laetitia Paul Lorenzo L. Houle 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth W. Kistler/Daughter 8771 Hickory Hill, Walkersville, Maryland 21793 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition cemetery, crematory or other place) Resthaven Memorial November 6, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 2004 Frederick, Maryland Gardens 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00198 300 West Montgomery Ave., Rockville, MD 20850-2805 23a. Part1. Either the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Asthma Exacerbation disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Viral Syndrome Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the IF FEMALE esn 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy jo in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) ☐ Yes 2 No be detached the 9☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy performed 1 🔀 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 🔲 Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 XYes 2 No 2 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: of or Attending Fatter death. 5 Pending 1 XNatural after death. 1 Tyes 2 No investigation 2 Accident in by the 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospitel o within 24 hours aff To the Funerel Di 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055109 11-1-04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18550 Office Park Drive, Montgomery Village, Maryland 20886 Balnath Bhandary, M.D. 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month Year Physician 19, 2004 2:31 Oct. ADDISON LOUISE ALTCE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville CASEY HOUSE Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Months 1 ☐ M 2 ☐ ¥ 220-34-8128 76 Apr.18,1928 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County 28a-f ahow Examiner must be notified at 1 XYes 2 No Director Montgomery Kensington 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 5 10761 Shaftbury Street 20895 U.S.A. 23a by Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify: Specify Black 3 Widowed 4 □ Divorced "naturaf", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic avant, I've Madical 15. Decedent's Education (Specify only highest grade completed) than College (1-4or 5+) Elementary/Secondary (0-12) Domestic Home 7th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic avantance. Be Rosie Pratt 2 Louis Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6809 Nashville Rd Lanham, MD 20706 William Washington-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Þ Memorial Cem. 10/23/2004 Sandy Spring, MD * 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTICEMIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner GANGRENOUS LOWER LIMB Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit ARTERIAL INSUFFICIENCY Due to (or as a consequence of) sician Box 68760. DIABETES MELLITUS Physician/Medical d IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown CONGESTIVE HEART FAILURE Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CHRONIC RENAL FAILURE autopsy perform 2 XNo 1 ☐ Yes 1 Tes 2[]X\o Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Other: 4 Nursing Home 5 Residence 6 State (Specify) Hospice Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 2 1 Tes 2 XNo his 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred eral 28c. Injury at Work? 27. Manner of Death Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М death. 2 Accident hours after deat 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a Descritifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) the 29d, Date signed (Month, Dav. Year) 29c. License number of certifier 29b. Signature and to To 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville, MD20852 Charles Harrison, MD 6001 Muncaster Mill Rd 32. Registrar's Signature 31. Date filed (Month, Day, Year) market 21 2004 2 Chatel Registrar

State of Maryland / Department of Health and Mental Hygiene

				Certificate	of Death	Re	9. N2 0 0 Ls	34938			
	Physician	Decedent's Name (First, Middle, Last DOMALD		CD		2. Dete of Deeth Month	Day Year	3. Time of Death			
*	/Medical	DONALD 4a Fecility Name (If not institution, give	FRANK BYRD,	3K•	4b. City, Town, or Lo	10 ocation of Death	18 2004 4c. County of Death				
7	Examiner	5959 Eskr			Galesto	wn	Dorchesta				
its	Funeral Director	5. Social Security Number 6. Security Number 230-48-1814	ex 7. Age (In yrs.	Months	Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth (Month, Day, 07 22	Year) Coi	nplece (State or Foreign untry) RYLAND			
	D	Usuel Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Location				10d. Inside City Limits			
	danyis daho dan	MARYLAND Dorchest		ALESTOWN				1 Yes 2 No			
	rect	10e. Street and Number		10f. Zip 0	ode	10	g. Citizen of Whet Co	untry?			
	23a o	5959 ESKRIDGE	ROAD		973		U.S.A				
020	filed within 72 hours efter death with the Manyland Hygiene. ther than "naturel", or frame 23s or 28s-f show ent, the Madical Exeminer must be notified at e.C. Completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	J,S. 13. Was Decede If Yes, specif	nt of Hispenic Origin? (Sp y Cuban, Mexican, Puerto X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WH				
5-0	72 ho natur dical	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16e. Decedent's Usual (Give kind of work	done during most of work	ing 1	6b. Kind of Business/	ndustry			
121	ed within 72 houygiene. or than "nature it, the Wadical E	Elementary/Secondary (0-12)	College (1-4or 5+)	Repair			Engine				
d 2	be filed tel Hygie d other event, E Be Co	17. Father's Neme (First, Middle, Last)		Керитт	18. Mother's Name	e (First, Middle, M	faiden Sumame)				
/lan	should be filed within and Mentel Hygiene. marked other than imetic event, the Mentel To Be Comp	Walter Hubbard	Byrd		Eunice	Rose Ta	ylor				
Baltimore, Maryland 21215-0020	nd 2 set of the or tract	19a. Informant's Name/Relationship (7 Jamie Pastula/D	aughter	5959 Esk	Street and Number or Run Pidge Road,						
more	pernit. Peges 1 end 2 Depertment of Heelth e mportant: if Item 27 is iny Injury or other tra 2008.	20a. Method of Disposition 1	Hemoval from State	Place of Disposition (Name cemetery, crematory or oth nancock Ceme	1 _		oc. Location - City or one Onancock ,				
Balti	permit. Pege Depertment of Important: If any Injury or once.	21. Signeture of Funeral Service Licen		22. Name and	Address of Facility Wi	lliams F	uneral Hom				
		23a. Part 1. Enter the disease, or companies of heart failure. List only of	plications that caused the dea					Approximate			
1	Physician	shock or heart failure. List only o					1	Interval Between Onset and Death			
-	/Medical Examiner	Immediate Cause (Final disease or condition	Chron	ric Obst	ruitine P	smonar	y Piseuse	20415			
		Immediate Cause (Final disease or condition resulting in death) a. Chronic Obstructive Polymonary Piseuse 2045 Due to (or as a consequence of):									
Т	executed in and ial-trensit		b	or as a consequence of):			1				
oʻ	an andurial-tre	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	550.10 (or 20 2 001100 4 001100 0.1,.			1				
68760,	eath certificate be executed attending physician and for use as the burial-trensit clan/Medical Examir	that initiated events resulting in death) Last	CDue to (or as a consequence of):							
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Вох	atten d for u	Pert II. Other eignificant conditions or	ontributing to death but not re	sulting in the underlying ca	ise given in Part I	23b. Did tob	pacco use contribute	to the cause of death?			
P.O.	at the death ced by the attend etached for us. Physician/	Per(ii. Other eignincant conditions of	minipuling to death but not re-	suring in the underlying out	Joo grown III are i			obably 4 ☐ Unknown			
	res that the de signed by the a be detached i							Mary autopou findings			
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Į (Z 25 5	examiner? 1 ☐ Yes 2 ☐ No		☐ ER/Outpatient 3☐ DOA	1		nce 6 Other (Spec	city)			
n o	Ing Ph	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of lnjury M	c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred				
Division	tal or Attending P rs after death. el Director: Attert ed in by the funer. Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		nome, farm, street, factory,		28f. Location (Stre City or Town,	eet and Number or Ru Stete)	ral Route Number,			
	Hospi 24 hou Funer tely fill	29a. Certifier 1 Certifying Phyone (Check only one) 2 Medical Exam	ysician: To the best of my known in the basis of examinating and manner stated.	owledge, death occurred at ation and/or investigation, i	the time, date and place, n my opinion, death occurr	and due to the car red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)			
	within 2 To the comple	29b. Signature and title of certifier	and mainter stated.	29c.	License number	29	d. Date signed (Month	n, Day, Year)			
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		30. Name end eddress of person who o			300 N.D. LASVE		9956				
1	State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Sign								

			1 - For Amend Item Registrar	19a-b per	Maryland / Den informant Cei	stment of the	<u>lealth</u> and M Death	lental Hyg	ien 2004	34939	
			Decedent's Name (First, Middle,	Last)				2. Date of Deat Month	h _	3. Time of Death	
	Physici		Rofflow	Cecil	Blackme	r, Jr.			25, 2004	4:15 a.m.	
	/Medic Examin		4a. Facility Name (If not institution,	give street and number	er)	4b. City, Town, or	Location of Death		4c. County of Deat	h	
			17722 Lawrenc	e Street		St.	Inigoes		St. Ma	ry's	
	Funeral		5. Social Security Number	5. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Date of Birth (Month, Day,	Year) Co	hplace (State or Foreign ountry)	
	Director	Ļ	262-22-3699	TEM ZUP	80 Yrs.			Apr.22,	1924 F1	orida	
	pur *	1	Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
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	28a-	Director	Maryland St. M	lary's	5	t. Inigoe	:S	1	Og. Citizen of What Co	ountry?	
	with Sa or		17722 Lawrence	Stroot		2	20684		United St	ates	
	ns 2:	era	11. Marital Status	12. Was Decede	nt Ever in U.S. 13.	_	ispanic Origin? (Spe n, Mexican, Puerto	cify Yes or No-	14. Race - Ame	rican Indian,	
36	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinat must be a willied at	by Funeral	1 ☐ Never Married 2 ☑ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force of 1 XYes 2[If Yes, Give Year or Date	□No 1941- 1947	if Yes, specify Cuba 1 ☐ Yes 2 2 No	Specify:	Hican, etc.)	Black, Whit	e, etc. hite	
Maryland 21215-0036	72 hou 'natura dical E	eted	15. Decedent' (Specify only highest		(Give	dent's Usual Occup	during most of worki	ing	16b. Kind of Business/	Industry	
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d 2	12 should be filed w n and Menfal Hygie 1s marked other ti reumatic event, IL		17. Father's Name (First, Middle, L	ast)		10 00000	18. Mother's Name			7.00	
lan	ld be enfal ked c	To Be	Rofflow Cecil E	lackmer			Geneva	Catheri	ne Bechtel		
ary	shou nd M mar		19a. Informant's Name/Relationsh Caroline M. Blac	p (Type, Print)	1967 Majli	ng Address (Street	and Number or Rura	il Route Number	City or Town, State, 2	Zip Code)	
	Health a tem 27 is		Catherine Black	mer / Wife				t. Inig	oes, Maryla	and 20684	
J.	of He of He item		20a. Method of Disposition 1 □ Burial 2 □ Cremation	2 Demoved from Sta	20b. Place of Dispo cemetery, cre	osition (Name of matory or other place		Date	20c. Location - City or	Town, State	
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Baltimore,	permit. Pages Department of Importent: If it any injury or o		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Brinsfield Funeral Hor								
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п			23a. Part 1. Enter the disease or of shock, or heart failure. List of	complications that caused on each	sed the death. Do not ent			or respiratory arre	est,	Approximate Interval Between Onset and Death	
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4	/Medical		resulting in death)	Due to (or	as a consequence of):						
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10	g Phys er this ieral di		27. Manner of Death	28a. Date of	Injury 28b. Time o	f 28c. Injur Wor	y at k?	28d. Describe ho	w injury occurred		
ion	Attending ir death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investig		Say / Say		Yes 2□No				
Division	or Atte	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	and 289. Place of	Injury - At home, farm, st , etc. (Specify)	reet, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ural Route Number,	
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edical			est of my knowledge, deat is of examination and/or in r stated.						
	To th Mithin To th	Me	29b. Signature and title of certifier	Α		29c. Licens	e number	2	9d. Date signed (Mont	h, Day, Year)	
			1	Shah		D	47066		0.25.0	4	
			30. Name and address of person v								
			Avani D. Shah,		2650 Cedar I	ane Cour	t, Leonard	dtown, M	aryland 20	650	
	Sta Regist		31. Date filod (Month, Day, Year)	2004	istrar's Signature	park					

State of Maryland / Department of Health and Mental Hygien 200 la 34940 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Virginia October 22, Bowman 8:25 P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Coffman Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Months 1 ☐ M 27 F Director 220-26-0223 March 16,1916 Maryland Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location Items 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 X Yes 2 No MDWashington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 832 Dewey Ave. 21742 U.S.A. Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "neturel", or 1 ☐ Yes 2X No Specify: ģ If Yes, Give Year or Dates: Specify: White 3 XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Teletype Operator Retail treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) int of Health and Mental H
t: If Item 27 Is marked ott
y or other treumetic even David L. Stouffer Lily V. Leathers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy L. Oller/Daughter 832 Dewey Ave. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. ^¹ 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 10/26/2004 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown, MD 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode or trying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Que to (or as a c Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) Box 68760. physician IF FEMALE nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for in the past 12 mont 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown 9 Unknown ۾ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe page 2 should Be Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 NO 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Flursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manne 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Matural 5 Pending death. investigation 2 Accident 1 ☐ Yes 2 ☐ No To the Hospitel or Attend within 24 hours after death To the Funerel Director; the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. R strar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Pauline Lucille Brown October 22 2004 9:20 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Julia Manor Health Care Center Hagerstown MD Washington If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖾 F 219-05-2702 Director 83 March 28 1921 Pennsylvania Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at ty Yes 2□No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 333 Mill Street 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White à 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Assembler Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental P Elliott Turner ၉ Mary Harbaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) parmit. Peges 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum Ann M. Hartley / Daughter 15 Marview Dr Berlin MD 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 10/26/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityRest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examine attanding physicien and for usa es the burial-transit Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) resulting in death) Last signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 Probably 4 Unknown þ been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 certificate 1 ☐ Yes 2 ☐ No 11 Yas 2 XN0 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Shursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ō To the Hospital Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Deste 5351 2H-0 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar 1136 CPAL COURT

31. Date filed (Month, 1907ed 5 2004 32. Resistrar's Signature

HNGERSTOWN

IND 21740-DR. KAHLID WASCEM

State of Maryland / Department of Health and Mental Hygien 2 1

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/Medical	
Examiner	

Funeral

Director r than "naturat", or items 23a or 28a-f show the Medical Examiner must be notified at within 72 hours after othar than

Maryland 21215-0036

Baltimore,

2 should be f and Mental I markad

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Physician /Medical Examiner

attending physician and for use as the burial-transit certificate be executed Box 68760, Division of Vital Records, P.O. To the Hospitel or Attending Physicien: within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director,

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month BURKE CHARLOTTE 19 5.10PM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death MOntgomery Fairland Nursing Home Silver Spring If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 1 F Yrs Newberry S.C. 249-38-7735 91 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits tx Yes 2 No **Funeral Director** S.C. Greenville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29601 USA 207 Echols Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black δ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 6th. Housekeeper Sendran Fur Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dominick Alma Reeder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carl S. Reeder/Son 1205 Kenyon St. N.W. Washington, D.C. 20010 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State 10-23-04 Peidmont, S.C. Resthaven Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee permit.
Departr
Importa 22. Name and Address of Facility Marshall's Funeral Home 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) TO THRIVE AILURE Due to (or as a consequence of): MALABSORPTION SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🔯 No 25. Was case referred to medical examiner? Medical Certification; To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4☑ Nursing Home 5☐ Residence 6☐ Other (Specify) 1 ☐ Yes 2 2 No 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PHY SICIAN 20061096 10/20/04 30. Name an address of person who completed cause of death (Item 23a) (Type, Print) GOLLAPALLI MD 8609 SELOND AVENUE, SILVER SPRINGMP20910 31. Date filed (Month, Day, Year) . Registrar's Signature State OCT 2 1 2004

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mary	/land / D	epartment of H Certificate of I	lealth and N D <i>eath</i>		ene2004	34943
	Physicia		Decedent's Name (First, Middle, Last) MAXINE	N. BR	00KS			2. Date of Death	T9 2004	3. Time of Death 5:20 A M
	/Medic Examin		4a. Facility Name (If not institution, give s				Location of Death		4c. County of Dea	
e de po	Funeral Director		+30 10 2/21	M 2⊠F	yrs. last birtl	nday) If Under 1 Year Months Days	ERSBURG If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct. 12	Q Ric	thplace (State or Foreign puntry) I exas
	yland now		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town	or Location				10d. Inside City Limits
	se Mar Sa-f et	ctor	Md. Montgo	omery	Gait	thersburg				1 XYes 2 No
	death with the Maryland ms 23s or 28s-f ehow rmust be notified at	Dire	10e. Street and Number 333 Russell Avenu	ie, #521		10f. Zip Code	20877		g. Citizen of What Co United St	•
336	be filed within 72 hours after death with the Marylar Ital Hygiene. d other than "netural", or liems 23s or 28s-f ehow event. Ital Medical Examene must be notified at	by Funeral Director		2. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S.	13. Was Decedent of Hi If Yes, specify Cuba			14. Race - Ame Black, White Specify:	erican Indian,
15-0036	72 hor	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a.	Decedent's Usual Occupa (Give kind of work done of	during most of work	ing 10	Sb. Kind of Business	Industry
N	iene. r than '	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		iite. DO NOT use retired tatistician			U. S. Gov	ernment
nd	be filed wit tal Hygien d other than	Be C	17. Father's Name (First, Middle, Last)			00013010101	18. Mother's Name	e (First, Middle, Ma		
Maryland 21		은	Charles F. Na 19a. Informant's Name/Relationship (Typ	fus e. Print)	19b	Mailing Address (Street a		Ramsey	City or Town State	Zin Codel
	and 2 s alth an 127 is er trau		Edward E. Brooks			16 Exodus D			, , , , ,	0882
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke ery injury or other traumatic once.		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	moval from State		Disposition (Name of c, crematory or other place olitan Crem			oc. Location - City or Alexandria	Town, State a, Virginia
Balt	permit. Pag Department important: eny injury o		21. Signature of Funeral Service License	ale		22 Name and Address Muriel H. P.O. Bo	Barber Facility Barber F	Funeral H avtonsvi	ome lle, Md.	20882
	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	tricu	ot enter the mode of dying				Approximate Interval Between Onset and Death Sudden
45	Examiner		Sequentially list conditions b.	Due to (or as a co	acrt	·	ut fa	lave		3 years
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Directo (or as a co	nsequence o		-f-cien	10/		7 4901
68760,	ificate be executed physicien and as the burial-transit	edical Exa	resulting in death) Last	Due to (or as a co	ensequence o	():				
O. Box	The law requires that the death certifics to has been signed by the attending phoage 2 should be detached for use as to	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 2 No 9 Unknown 2 Unknown 2 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 9 Unknown 2 2 No 2 2 2 2 2 2 2 2 2							23d. Date of del Month	ivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions cont	ributing to death but no	ot resulting in	the underlying cause give	on in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to	the cause of death?
Vital Records,		Completed	Normal pre	ssure h	y clw	cephalas	<u>.</u>	24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	spital:		othe	NP.	(Check only one)		Acid II
Division of	To the Hospital or Attending Physician: Yo the Funeral Director: After this certification completely filled in by the funeral director.	atlon: To	1 Yes No Pending 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 EP/Outs 28b. Ti	me of 28c. Injury	4 Nursing no	me 5 ∐ Residene 28d. Describe how	ce 6 Cther (Specinjury occurred	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1
DIVIS	tal or Atters safter des	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S		n, street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	he Hospi in 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) (Check only one) (Check only one)	cien: To the best of m er: On the basis of exa and manner stated.	y knowledge, amination and	death occurred at the tim for investigation, in my op	e, date and place, inion, death occurr	and due to the caused at the time, date	se(s) and manner as and place, and due	stated, to the cause(s)
•	To T To T com	Σ	29b. Signature and title of certifier	. 0. 1.	15	29c. License			. Date signed (Month	
	5		30. Name/and/address of person who con	pleted cause of death	(Item 23a) (I	ype, Print)	117299		ctoser	17,2004
			John Q. N	lehich	911	Duriell 1	m. 6	q: thenis	my Mol	20879
	Sta Registr		31. Dáte filed (Month, Day, Year) OCT 20 20	32. Registrar's	Signature	5 spork	2/		-	,

04-6671 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygien 200 l BEVERLY BROWN 1 - For State Registrar 34944 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Beverly grown 2004 0549 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES PRINCE GEORGES HOSPITAL CENTER CHEVERLY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Şex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F 214-52-0736 Usual Residence of Decedent 55 Director May 26. Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Medical Examinar most be notified at 1 Yes 2 □ No Prince Georges by Funeral Director Cheveri 10e. Street and Number 10g. Citizen of What Country? 20743 601 Street rown 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates: Specify Specify Black 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) iould be fited within 7; I Mental Hygiene. Parked other then "n Elementary/Secondary (0-12) College (1-4or 5+) Operator Computer redera 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked Bailey harles Hytolia ဂ္ Pages 1 and 2 should nent of Health and Men oung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat - p Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 is any injury or other treu once. 27426 Burrsville Rd. Denton, MD. 21629 Gilmore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 □ Burial 2 12 Cremation 3 □ Removal from State Mid Shore Cremation 10/19/04 Cambridge, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
HENRY FUNERAL HOME P.A. 21. Signature of Funeral Service Licensee anelle 510 Washington St. Combridge, MD. 21613
the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate 23a. Pan1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or sequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) the a detached 9 Unknown 9 Unknown à signed to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 5 2 No 3 Probably 4 □Unknown 1 ☐ Yes Completed been 24a. Was an autopsy performed? certificate Yes 2 🗆 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Xes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Manner of Death 28b. Time of 28d. Describe how injury occurred After Natural 5 Pending Injury М 1 Tes 2 No investigation 2 Accident 3 Suicide

or Attending Physicien: death. after death filled in by within 24 hours a

24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ene) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E OCT. 16, 2004 and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

SNO locke

111 Penn Street, Baltimore, Maryland 21201

 A^{M}

1 - State Registrar Certificate of Death Reg. No.	34945
1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year	3. Time of Death
Physician /Medical LESLIE ANN CIMETTA-BOWMAN October 19, 200	04 2020 ^M
Examiner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	
Atlantic General Hospital Berlin Worcest 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birth 9. Birth	olace (State or Foreign
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year If Under 24 Hrs. Months Days Hours Min. (Month, Day, Year) 1 2 - 22 - 58 NJ	ntry)
Usual Residence of Decedent	
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
10a. State 10b. County 10c. City, fown or Location 10b. County 10c. City, fown or Location 10c. City, fown or Loca	
106. Street and Number 107. Zip Code 109. Cilizen of What Court 21811 USA	indy :
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11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Black, White, 1 ✓ Yes, Siewe 1 ✓ Yes 2 ☑ No specify: Specify:	
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15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/In (Give kind of work done during most of working life. DO NOT use retired) Nurse Practitioner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame)	
Alphonse Cimetta Mary Ann Rizzo	
17. Father's Name (First, Middle, Last) Alphonse Cimetta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zig	Code)
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20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or To cemetery, crematory or other place)	
20a. Method of Disposition Section Date	1a .
Ullrich Funeral Home Berlin, M	13
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician Immediate Cause (Final disease or condition a metatatic adenocarcinoma	Onset and Death
/Medical resulting in death) Due to (or as a consequence of):	
Examiner Sequentially list conditions, b. Due to (or as a consequence of).	_
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury)	
Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
17.2 ate be en thysician the buria	
The state of the s	
IF FEMALE: 23d. Date of deliv. 1	ery Day Year
O P P P P P P P P P P P P P P P P P P P	
	the cause of death?
Y Y S S S S S S S S S S S S S S S S S S	bably 4 Honknown
1 Yes 2 No 3 Protein Yes 2 No 3 Pr	opsy findings available ompletion of cause of
autopsy prior to comperior and the second death? autopsy performed? performed? 1 Yes 2 No 1 Yes	
Per 1	
50 to 0 f 5 m	fy)
I → C S S S O 1 ⊡Natural 5 □ Pending (Montin, Day Year) Injury Work?	
	al Route Number,
3 Suicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 4 Homicide 5 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 See. Place of Injury - At home, farm, street, factory, office 5 See. Place of Injury - At home, farm, street, factory, office 6 City or Town, State) 5 See. Place of Injury - At home, farm, street, factory, office 6 City or Town, State)	
2 Accident 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rung City or Town, State) 2 Accident 3 Suicide 4 Homicide 6 Certifier (Check only one) 29a. Certi	
and manner stated.	
29b. Signature and Atle of certifier 29c. License number 29d. Date signed (Month, D53612 10/19/04	L
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	0 - 7 / 1
	1 (1 [6/]]
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			1 - For State Registrar	State of Ma	aryland / [Departme Certifica					ene . N2 0 0 4	349	46
ı	Physici		1. Decedent's Name (First, Middle, L Irma Hope CAVE	ast)					ر ا	2. Date of Death Month	Day Yea		Death P M
	/Medic Examin		4a. Facility Name (If not institution, g	ive street and number)		4b. C	ty, Town, or	Location			4c. County of De	*	
			Washington Coun	ty Hospital	L		agers				Washing	ton	
	Funeral Director		5. Social Security Number 6. 212-14-7706 Usual Residence of Decedent	Sex 1□M 2\\\X\\F\\\	(In yrs. last bir 84	Yrs. If Un-	der 1 Year IS Days	If Under Hours	Min.	B. Date of Birth (Month, Day,) Nov. 11		irthplace (State or Country) irginia	Foreign
	land ow		10a. State 10b. County		10c. City, Tow	n or Location	-					10d. Inside City	y Limits
	a-f sh	ţċ	Maryland Washin	gton	На	gersto	wn					1 □ Yes	≱ □ No
	ith the	Director	10e. Street and Number				Zip Code			100	. Citizen of What (Country?	
	ath w		732 Interval Roa					1740			U.S.A		
36	n 72 hours after death with the Maryland "neturel", or Hems 23e or 28a-f show gdical Ever it at rings be redified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			cedent of Hi pecify Cuba 2X No	spanic Ori n, Mexicar Specify:		ify Yes or No- ican, etc.)	Specify:		
21215-0036	2 hou		15. Decedent's	Education	16a.	Decedent's U	sual Occupa	ation		16	Sb. Kind of Busines	White s/Industry	
215	c 2	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed) College (1-4or 5	+)	(Give kind of life. DO NO	work done a use retired	luring mos)	st of working	7			
		Cou	11	0		Homem	aker				Her own	home	
Maryland	ed all	Be	17. Father's Name (First, Middle, La.	,						First, Middle, Ma	· ·		
7	should be and Mental s markad o umatic eva	5	Albert Warren De 19a. Informant's Name/Relationship		10h	Mailing Addr	on /Street o				Cunningha Dity or Town, State,		
Z	d 2 s th ar trau		Gregory Dixon -								ille, Md.		
ē,	ges 1 an t of Heal If item 2 or other		20a. Method of Disposition		20b. Place of	Disposition (/	lame of		Dai		c. Location - City o		
Baltimore,			1 □XBurial 2 □ Cremation 3 3 4 □ Donation 5 □ Other (Spec		ļ	Lawn M		1	10/26	/04 на	gerstown	Marv1a	nd
alti	permit. Page Department of Important: If any injury or once.		21. Signatural Funeral Service Lic	enseen M	G	The second second	and Addres				Funeral H		na -
m			Coll	1//1//	enny	45	E. W13	Lson	Blvd.	Hagers	stown, Md	. 21740	
23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of a shock, or heart failure. List only one cause on each line. Physician / Medical disease or condition a. Due to (or as a consequence of): Examiner Due to (or as a consequence of):												Approximate Interval Betwoonset and Do	eath
	/Medical Examiner		resulting in death)	Due to (or as a	a consequence	of):							
40		Je l	Sequentially list conditions, if any, leading to immediate		consequence		in the	cha	روروب	> m	reary	315	
	uted d ansit	Examiner	Cause (Disease or injury										
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8760,	ate be ex hysician he burial	icai		d									
9	ntifica ng ph s as th	e	IF FEMALE:										
.O. Box	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of the second of the s	2 Fetal death	3 ☐Ectopid 5 ☐ Other					23d. Date of de Month		ear
۵.	de de E		Part II. Other significant conditions	contributing to death bu	ıt not resulting ir	the underlying	g cause give	n in Part I		23e. Did toba	co use contribute	to the cause of de-	ath?
rds	quires n sign	ed by	congentin He	art Fari	un	Anter	2 0/2	clera	TEC	1 ☐ Yes	2 □ No 3 □ F	robably 4 🖰U	Tknown
Vital Records,	aw require ts been sig 2 should b	Completed	Cardio Vancul							24a. Was an	24b. Were a	utopsy findings av	vailable
Ä	9 2 0	шо								autopsy performe	d? death?	completion of cau s 2□ No	129 Ot
ita		BeC	25. Was case referred to medical examiner?					26. Place	of Death (Check only one)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
of V	Physician: this certific al director,	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Umpaties		tpatient 3	DOA Othe	r: 4 □ Nu	ursing Home	5 Residence	e 6 ⊡Other (Sp	ecify)	
		inol.	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injur (Month, Day		ime of njury	28c. Injury Work			d. Describe how	injury occurred		
Division	Attending r death. ector: After by the fune	icat	2 Accident investigate 3 Suicide 6 Could not	be 200 Bloco of Injur	Inv. At home fa	M stract fact		′es 2 □		f Location (Stra	et and Number or F	Rum I Pauta Mumb	
Ď	in Dig	Certification:	4 Homicide determine	building, etc	. (Specify)	iiii, stieet, iact	ory, office		20	City or Town, S	State)	iurai nobie ivumbe	91,
	e Hospitel or 24 hours afte e Funerel Dir etely filled in	edical C	29a. Certifier 1 Certifying R (Check only one) 2 Medical Ex-	Physician: To the best of aminer: On the basis of and manner sta	examination and	, death occum d/or investigati	ed at the tim on, in my op	e, date an inion, dea	nd place, and ath occurred	d due to the caus at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)	
	To the Hos within 24 ho To the Fun completely	Me	29b. Signature and title of certifier			2	9c. License	number		29d	Date signed (Mon	th, Day, Year)	
			- Conta	MD			DI	8010	7	O	CT 22	2004	
()	14-3		30. Name and address of person wh	TTA MO	34	o mi	L L S	7 1	MAG		ww m		40
	Sta Registr		31. Date filed (Month 077 eg) 5	2004 32. Redistra	r's Signature	Sperk	م						

State of Maryland / Department of Health and Mental Hygien 2004 34947 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:38 PMM Hapsy Louise Coates October 22 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Williamsport Washington County Homewood Retirement Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Director 251-26-3701 88 Yrs 1916 South Carolina October 1 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Williamsport 1 ☐ Yes 2X No Directo Maryland | Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16505 Virginia Ave 21795 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - Americen Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 →No White Completed by Specify 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food Preperation unknown Nursing Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baker Hulon, Sr. Peral (unknown) Hulon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Granddaughter) 18407 Rose 20b. Place of Disposition (Name of cemetery, crematory or other place) Sherry L. Lum 18407 Roseglow Ave. Hagerstown Maryland 21740 Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If Ite
any Injury or otl 1 ▼ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Riverside Cemetery Oct. 26, 2004 Dillion S. Carolina 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown Maryland 21742 21. Signature of Funeral Service Licensee 23a. Part1. Enter the sease, or complication, that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterial Sclerosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Discase or injury) Examiner Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 X No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Severe Alzheimers 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibliration 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 2XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 XNatural 5 Pending

1 ☐ Yes 2 ☐ No

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

The law requires that the death certificate be executed burial-transi nding physician and Division of Vital Records, P.O. Box 68760, the use as s been signed by the should be detached Hospitel or Attending Physicien: After after death Director: / filled in by within 24 hours a

the Maryland

72 hours after death

Baltimore, Maryland 21215-0036

7 is marked other than "natural, or iteme 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

al Hygiene.

ss 1 and 2 should be fi of Health and Mental H Item 27 Is marked of and Mental

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Allen Ditto 747 Northern Avenue Hagerstown, MD 21742 31. Date filed (Month Day Year)

investigation

6 Could not be determined

2 Accident

3 Suicide

29a. Certifie

Medical

4 Homicide

(Check only one)

29b. Signature and title of certifier

32. Agistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1- State of Maryland / Dep	artment of Health and Mertificate of Death	ental Hygie _{Reg.}		34948						
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death						
	Physici /Medic		Jane Grim Combs		OCTOBER	Day Year 26 2004	11:10 a™						
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	1						
		1	St. Mary's Hospital	Leonardtown If Under 1 Year If Under 24 Hrs.	1811	St. Mary							
	Funeral Director		5. Social Security Number 235-14-9182 Usual Residence of Decedent 6. Sex 1	Months Days Hours Min.	8. Date of Birth (Month, Day, Ye March 1,1	ar) Co	nplace (State or Foreign untry) nsylvania						
	show		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits						
	Man a-f sh	tor	Maryland St. Mary's Great M	tills			1 ☐ Yes 2X No						
	th the	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Co	untry?						
	23a	ral	21720 Chancellors Run Road	20634		U.S.A.							
21215-0036	ges 1 and 2 should be illed within 72 hours after death with the Maryland It of Health and Mental Hygiene. It of Health and Mental Hygiene. It is marked other than "netural; or Items 23a or 28a-f show or other traumatic event, the Mached Exacitizer rust be notified at	Completed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No of If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:							
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N	filed within Hygiene. other than ent, its M	Cor		itchboard Operator		U.S. Gove	rnment						
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Itte M.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name		,							
Σ	should be f and Mental h s marked of umatic eve	To	Raymond Grim 19a. Informant's Name/Relationship (Type, Print) 19b. Mai	Romaine ing Address (Street and Number or Rural	Lafayett		in Code)						
Ma	and 2 s ealth an n 27 Is er trau			5 Garden Point Lane									
ē,	Heal Heal Hem		20a. Method of Disposition 20b. Place of Disp										
OE	Pages nent of I int: If its iry or o		Abdital 2 Celliation 3 Helioval ibili State		1-04	Levinston	Park MD						
	permit. Pages 1 and 2. Department of Health at Important: If item 27 is any injury or other traignes.		1 X Burial 2 Cremation 3 Removal from State '4 Donation 5 Other (Specify) Evergreen Mem. Gdns. 11-1-04 Lexington Park, Memoral Service Licensee 22. Name and Address of Facility Evergreen Mem. Gdns. Brinsfield Funeral Home, P. A										
			21. Signature of Fineral Service Licensee 22. Name and Address of Facility P.O. Box 279 Leonardtown, Maryland 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure.										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Failure			Onset and Death						
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.O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	very Day Year						
rds, P.	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		co use contribute to 2 □ No 3 □ Pro	the cause of death?						
		Completed by			24a. Was an autopsy performed 1 Yes 2 🟋	? death?	opsy findings available ompletion of cause of						
Vital	i cien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)								
of	Physicien: this certific ral director,	To.	1 Tes 2 Privo		e 5 Residence	6 Other (Speci	fy)						
	After After fune	tion	27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 28a. Date of Injury (Month, Day Year)	Work? M 1 □ Yes 2 □ No	od. Describe flow if	ijury occurred							
Division	or Attending Ph after death. Director: After th I in by the funeral	Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)		Bf. Location (Street City or Town, St	•	·						
_	To the Hospitel or Attens within 24 hours after death To the Funerel Director: completely filled in by the	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal (Check only one) 1 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, are nvestigation, in my opinion, death occurred	nd due to the cause d at the time, date a	(s) and manner as	stated. to the cause(s)						
	To th within To th compl	Me	29b. Separture and title of certifier	29c. License number	29d. I	Date signed (Month,	Day, Year)						
			1 ATC M	1) 25230	1	0/261	104						
			30. Name and address of person who completed cause of death (Item 23a) (Type DAVID ALLEN PO BX 527 LEONARDTO										
	Sta Registr		31. Date filed (Month, Day, Year) OCT 2 7 2004 32. Registrar's Signature	park									

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier 34950 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 1:00 p Cook October | 15, 2004 Josephine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 12312 Loft Lane Silver Spring If Under 1 Year | If Under 24 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2√2√F Director 68 Sept 23 1936 N. Dakota 501 30 4423 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Directo Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 20904 12312 Loft Lane Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married Am Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Imporent: If Item 27 is marked oth any injury or other treumatic event once. Be Joseph Schmalz Juliana Neiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Herbert Gene Cook / Husband 12312 Loft Lane Silver Spring, Maryland 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition * 4 ☐ Donation 5 ☐ Other (Specify) 10/20/2004 Brentwood, Maryland Ft Lincoln Crematory 21. Signature of Funeral Sayvice Licens 22. Name and Address of Facility Hines Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Lung Cancer 9 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown **XX**Yes 2 🗆 No Completed peen 24a. Was an autopsy performed?
1 Yes 224No 24b. Were autopsy findings available prior to completion of cause of death? has certificate 2X No 1 Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home Residence 6 Other (Specify) မ 1 Tyes 2 No 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Director: After Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No death. M 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D29675 10/19/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ralph Bocca, M.D. 6420 Rockledge Drive #4100 Bethesda, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 20 2004 OCT Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 34951 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 2004 Mary Ann Crandell October 15 10:40p.[™] /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 500 Patuxent Ave. Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□M 21 F Yrs. 220-12-0523 79 9, Director 1924 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits , or Items 23s or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Dorchester Wingate 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2013 Farm Creek Road 21675 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ģ 3 ₩idowed 4 Divorced "neturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) is marked other then Elementary/Secondary (0-12) College (1-4or 5+) clerk oil company 10 or other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If tiem 27 is marked oth any jujury or other treumatic event <u>once</u>. Be Thomas Powley Archie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wayne Crandell 626 Mansfield Rd. Essex, MD 21221 son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/04 1 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. Hurlock, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD Dilem 19. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician METASTATIC NON-Small month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit to the Hospitel or Attending Physicien: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1⊈ Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an performed Yes 241 1 Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specifysons home 1 ☐ Yes 2 No Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred after death. 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3355/ completed cause of death (Item 23a) (Type, Print) FRANKIN SQ. DR. #314, BAHIMORE 21237 Registras Signature 31. Date filed (Month, Da State Registrar

			1 - For State Registrar	State of M	arylan	-			lealth an Death	nd Mental	Hygier	/ 11111	i 3	34952
	Physici	an	Decedent's Name (First, Middle	·						Mont		Day Ye	ar	. Time of Death
	/Medic		Virginia L. 4a. Facility Name (If not institution,				4b. Cit	y, Town, or	r Location of D	Oct		6, 200 4c. County of D		2:30 p ^M
	LXGIIIII	C.	Sunrise Ass						erna			Anne	Arui	ndel
	Funeral Director		5. Social Security Number 515-20-8587 Usuat Residence of Decedent	6. Sex 7. A(98	last birthday) Yrs.	Month:	er 1 Year Days	If Under 24 Hours	Hrs. 8. Date (Mon May	of Birth th, Day, Yea 7 31,1	9.	Birthplace Country)	(State or Foreign
	yland now		10a. State 10b. County		10c. Cit	y, Town or Lo							10d. I	Inside City Limits
	and shart sh	ctor	MD Anne	Arundel			Sev	erna	Park					1 ☐ Yes 2X No
	ath with th	ral Dire	10e. Street and Number 41 West McKinse						21146			Citizen of What Country? USA		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy righty or other traumatic event, the Medical Examiner roust be notified at anone.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri 3 🏿 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces of 1 Test Yes 2 1 1 Yes, Give Year or Dates:	?		Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No <i>Specify:</i>			or No-	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036		Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education grade completed) College (1-4or	5+)	(Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired) Honemaker			16b.	Kind of Busine		Ŋ	
	filed with Hygiene other tha	e Cor	17. Father's Name (First, Middle, I	ast)		l		nonen		Name (First, M	Aiddle, Maid		Home	
lan	ld be lental ked or	To Be	Lloyd Snyder	,						lotte A				
Maryland	1 and 2 should be f Health and Mental H Iem 27 is marked of other traumatic eve	-	19a. Informant's Name/Relationship (Type, Print) Sharon Wallenstrom/Niece 19b. Mailing Address (Street and Number or Rural Route of 682 Hendler Road, Severna								nber, City or Town, State, Zip Code)			
ore,	of He of He of item		20a. Method of Disposition 1 ☐ Burial 2 Cremation	3 □Removal from State	, 0	lace of Dispo emetery, crer	natory of	other plac	e) Oc	Date Ct. 18,		Location - City		
Baltimore	permit. Pages Department of I Important: If it any injury or o once.		' 4 □ Donation 5 □ Other (Sp	ecify)	Me	etro Cr		_		2004		ltimore		
Ba	permit. Departr Importa any inji		21. Signature of Fyneral Service I	All		B	arra	nco &	Sons,	P.A. S Hwy, S	evern	a Park	Funer	ral Home
	Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	complications that cause only one cause of each l	d the death								App	proximate ervat Between set and Death
8760,	e be executed /sician and e burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	SO/ salonseque Val	uence of):	ia	de	men	tia				
.O. Box 68	ires that the death certificat signed by the attending phy d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 to No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	t death 3	Ectopic Other	pregnancy specify)				23d. Date of Month	delivery Day	y Year
<u>α</u>	w requires that i been signed by should be deta	by	Part II. Other significant condition	s contributing to death I	out not res	ulting in the u	nderlying	cause give	en in Part I.	23e.		o use contribute		9
Records,	The law requate has been page 2 should	Completed							-	24a.	Was an autopsy performed?	prior death	o complet	findings available tion of cause of
Vital	Physician: this certificanal director,	Be	25. Was case referred to medical examiner?	Hospital:				0.15		Death (Check	only one)		A	ssisted
of	Physic ruthis carral direction	To to	1 Yes 2 No	ĭ □ Inpati		ER/Outpatien 28b. Time of			4 Nursir	ng Home 5 28d. Des		6 Mother (S	pecify)	iring
on	Attending ir death. ector: After by the fune	atlon	1 Natural 5 Pending 2 Accident investig		ay Year)	Injury	М	28c. Injury Work	k? Yes 2 □ No			,		
Division	To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification;	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	280. Place of in	jury - At ho tc. (Specif)	ome, farm, str	eet, facto	ery, office		28f. Loca City	tion (Street or Town, Sta	and Number or ite)	Rural Ros	ute Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Certifyin (Check only one)	Physician: To the best exeminer: On the basis of and manner s	of examina	wledge, death tion and/or inv	occurre vestigation	d at the timen, in my of	ne, date and p pinion, death o	place, and due to occurred at the	o the cause time, date a	(s) and manner nd place, and c	as stated lue to the	cause(s)
	To ti withi To ti comp	W	29b. Signature and title of certifier	1	~	- m	D 2	9c. License	070	25	29d. C	ate signed (Mo	onth, Day,	Year)
			30, Name and address of person	inger 860	1/4	terai	Print)	twg	Mill	lersvi	lle	MS	21	108
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	rar's Signa	ture	Jan . 15							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygier [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 06:34AM 2004 JO V /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number Examiner ROCKVILLE, MARTLAND MONTGOMERY SHADY GROVE ADVENTIST HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Yeer) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 1 M 2 F 01,2004 NONE NOV. MARYL Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or 28a-f show other traumatic avant, the Medical Examinar must be notified at 1 Xes 2 No MARYLAND MONTGOMERY Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a 20850 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after Never Married 2 Married 1 🗆 Yes 💆 👊 Baltimore, Maryland 21215-0036 "natural", or Specify: ASIAN þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If itam 27 is marked other than any injury or other traumatic avant College (1-4or 5+) Elementary/Secondary (0-12) INFANT 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be MING-FEN 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20850 HENGI MOTHER HOCKVILLE, MIS 122 ELINCROFT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) STERI BALTIMORE, MARYLAND DEC. 01,2004 CYCLE21. Signature of Jupenal Service Licensee 22 Name and Address of Facility 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician homozoni abnovna /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lissase or nighty that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown be detached for 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 🗌 Yes funeral director, page 2 should Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 🗆 No 1 Yes Yes Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 1 Tes 2 ER/Outpatient 3□ DOA Certification: To 28b. Time of Injury Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funaral Diractor: A 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) in by t 4 Homicide filled Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 104 berson who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Xockville Jud 20 9901 Medical SHEV-SHO ISENE MID 31. Date filed (Month, Day, Year)

NOV 0 4 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 34954 Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death OCTOBER MARY MATHIESON COUSINS 27, 2004 7:15 AM 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death WESTMINSTER NURSING & CONVALEXCENT CENTER WESTMINSTER CARROLL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours Months 1□M 2√2F 88 JANUARY 26,1916 SCOTLAND Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No CARROLL FINKSBURG 10f. Zip Code 10g, Citizen of Whet Country? 1500 DELAWARE COURT 21048 UNITED KINGDOM 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2X No Yes, Give 1 ☐ Yes 2 ☐ No Specify. Specify: WHITE 3√2 Widowed 4 □ Divorced Year or Detes 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TELLER BANK 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) ALEXANDER MACDOUGALL CATHERINE ROBERTSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN L. COUSINS/SON 1500 DELAWARE COURT, FINKSBURG, MD 21048 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) FIRST BAPTIST CHURCH 10/30/04 HEREFORD, MARYLAND 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 91 WILLIS STREET, WESTMINSTER, MD 21157 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Cell Come Due to (or as a consequence of): unkn Due to (or as a consequence of): ith? own

Physician /Medical Examiner

or Attending Physician: The law requires that the death certificete be exec Division of Vital Records, P.O. Box 68760,

eral Director: After this certificate has been si filled in by the funerel director, page 2 should

Be Completed by Physician/Medical Examiner

Certification: To

Medical

State

Registrar

Injury or

Physician

/Medical

Examiner

Funeral

Director

28a-f

permit. Peges 1 end 2 should be filed within 72 hours efter death with Department of Health end Mental Hygiene. Important: If Item 27 is merked other than "natural", or tems 23e or

n end Mental F is marked otl

Baltimore, Maryland 21215-0020

5. Social Security Number

MARYLAND

10

20a. Method of Disposition

10e, Street and Number

10a. Stete

Director

Funeral

Completed by

Be

217-40-3725

Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying

Immediate Cause (Final diseese or condition resulting in death)

that initieted events resulting in death) Last	1	c	Due to (or as a consequence of):
	L	d	
Part II. Other significant cor	nditions	contributing t	to death but not resulting in the underlying cause

that initieted events resulting in death) Last	Due to (or as a consequence of):		_
Part li. Other significant cor	ditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of c	
		24a. Was an autopsy performed? 24b. Were autopsy find available prior to completion of cau of deeth?	_

ı	25. Wes cese referre	d to medical				26.	Place of Dea	ath (Check only one)
	examiner? 1 ☐ Yes 2 🙀 N	0	Hospitel: 1 ☐ Inpatient 2 ☐	ER/Outpetient	3□	DOA Other:	Nursing H	Home 5 ☐ Residence 6 ☐ Other (Specify)
	27. Manner of Deeth 1 Natural 2 Accident	5 Pending investigation		28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, stree fy)	t, fact	tory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

£3a.	(Check only one)	2 Medicai E	֡
29b.	Signature a	nd title of certifier	

artifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. xaminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and manner stated.

29c. License number

1 ☐ Yes 2 🕱 No

1 ☐ Yes 2 ☐ No

(Type, Print) d address of person who completed cause of death (Item 23e)

31. Dete filed (Month, Day, Year) NOV 0 4 2004

Poole Road, Westminster, 32. Registrar's Signature

DHMH 16 Rev 6/95

within 24 hours e

completely

			1 - State of Ma	ryland / Depa <i>Cei</i>	artment of Health tificate of Death	and Mental H	ygiene 004 34955
	Physicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of D	David Maria
	/Medic	al	ANGELA MARIE DEAN		th Circ Town and anxion	10	20 200 M
	Examin	er	4a. Facility Name (If not institution, give street and number) LENINSULA REGIONAL MEDICAL	arras	4b. City, Town, or Location SAUIS BUILDING	ref	4c. County of Death Wicomic o
	Funeral Director		213-92-2948 ¹□M 2XF	(In yrs. last birthday) 27 Yrs.	Months Days Hours	7 24 Hrs. 8. Date of B (Month, D 7 / 13	irth (20), Year) 1977 9. Birthplace (State or Foreign Country) MD
	land ow		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	a-fsh	tor	MD Worcester	Snow I	Hill		1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What Country?
	ath w		6430 Whiton Crossing RD		21863		USA
920	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f show ollcal Exertified at	by Funerai	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:	0	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexica I ☐ Yes 2 ☐ Yoo Specify		14. Race - American Indian, Black, White, etc. Specify: White
5-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Deced	lent's Usual Occupation kind of work done during mos	st of working	16b. Kind of Business/Industry
21215-0036	d withir giene. rr than	Completed	Elementary/Secondary (0-12) College (1-4or 5-	+)	kind of work done during mos DO NOT use retired) memaker	• • • • • • • • • • • • • • • • • • •	Own Home
pu	8 H 9 8	Be	17. Father's Name (First, Middle, Last)			er's Name (First, Middl	
yla		ို	Rod Whitmoyer	401-44-11		eresa Popp	
Maryland	0 0 0		19a. Informant's Name/Relationship (Type, Print) Richard Dean, II				ber, City or Town, State, Zip Code) Snow Hill, MD 21863
	s 1 and 2 if Health item 27 other tre		20a. Method of Disposition	20b. Place of Dispo		10/21/04	20c. Location - City or Town, State
altimore,	0 0		1 Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify)		nlopen Crema		Frankford, DE
Balti	permit. Pag Department Importent: Il any injury o		21. Signator of June / Service Licensee	22	. Name and Address of Facili	he Burbac	ge Funeral Home
			23a. Part1. Enter the disease, of complications that caused shock, or heart failure. List only one cause on each lin		·	_	
,	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a	a consequence of):	/	I .	Onset and Death Mmmy Mmo
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):			
	cate be executed obysician and the burial-transit	Examin	that initiated events c. Due to (or as a	consequence of):			
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9		ledi	In course				
.O. Box	The law requires that the death certific te has been signed by the attending p vage 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Onknown 23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at 1 9 □ Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
s, P	res that igned b	by	Part II. Other significant conditions contributing to death but	t not resulting in the ur	nderlying cause given in Part		tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Ponknown
orc	v requir been s should	eted					
Vital Records,	The law cate has t page 2 s	Completed				24a. Wa auto peri 1 🗆 Yes	s an ppsy spring 24b. Were autopsy findings available prior to completion of cause of death? 2 2 70 1 79s 2 No
ital		Be C	25. Was case referred to medical examiner?		26. Place	e of Death (Check only	
of V	Physician: this certific ral director,	은	1 Yes 2 No Hospital: 1 Inpatier				sidence 6 Other (Specify)
		ion:	27. Manner of Death 1 Natural 5 Pending (Month, Day)	Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2		how injury occurred
Division	ten leat tor: the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Inju	ry - At home, farm, str			(Street and Number or Rural Route Number,
Ö	at or A s after Il Dire	Certification:	4 Homicide determined building, etc	(Specify)	,,	City or To	own, State)
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner state.	examination and/or inv	occurred at the time, date ar restigation, in my opinion, dea	nd place, and due to the ath occurred at the time	e cause(s) and manner as stated. , dato and place, and due to the cause(s)
	To the within 2 To the complet	W	29b. Signature and title of ce iffier		29c. License number	503	29d. Date signed (Month, Day, Year)
	,		30. Name and address of erson into completed cause of de	eath (Item 23a) (Type,	Print)		
1.1	1. 1		Joseph Grasso, M.O. 1	45 E. CI	ARKON ST.	SALISBUT	1 mg
	Sta Registr		31. Date filed (Month, Day, Year) 32. Fegistra OCT 2 2 2004	rs Signature	Print) ARCI/ 5T.		
	ricgisti	ui	001 ~ ~ 2007			*	

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (34956 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 10 **Physician** ATRICK 1425 Donert 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 040-26-1470 Yrs. Director 72 07-20-1932 Connecticut Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other then "netural", or terms 23e or 28e-f show eny Injury or other treumatic event, the Medical Examinar. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Salisbury **Funeral Director** Md WICOMICO 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 31531 2/804

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Spearin U.S. 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. No Pes 2 No If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 ☐ Married 21215-0020 1 Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced White Be Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Master Electrician 12 Electrical Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Doherty Mollie Dalton ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Pennie D. Savage/Daughter 31535 Spearin Road, Salisbury, Md. 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/17/04 Salisbury, Md. Salisbury Crematory 22. Name and Address of Facility
Hinman Funeral Home ge of Funeral Service Licensee 21. Signa MO0295 11673 Somerset Ave, Princess Anne, Md. 21853 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) MALIGNANT NEOPLASM OF UNKNOWN PRIMARY 2-3 MUNTHS Examiner Physiclan/Medical Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Due to for as a consequence of Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 1 Yes ours efter death.

erel Director: After this certific filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death
1 XNatural
2 ☐ Accident 28a. Date of tnjury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 I Homicide To the Hospital of within 24 hours of To the Funerel Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0058410 suga 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

26266 ARROWWOOD CT.

32. Redistrar's Signature

SALISBURY MD. 21801

Registrar

State

WARIS

OCT 2 0 2004

GHULAM

31. Date filed (Month, Day, Year)

			1- State of Maryland / Der State Amend Item 5 per in G838 12-8-0	partment of Health and Mental 4 tas Prtificate of Death	Hygiene 2004 34957
	Physici	an	1. Decedent's Name (First, Middle, Last) MABEL DOROTHY COATSWORTH DAVI:	Mont	
>	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	OBER 20 2004 9:40 P M 4c. County of Death
	_xumm		WILSON HEALTH CARE	GAITHERSBURG	MONTGOMERY
€? 5.	Funeral Director		52903a1.982riny18602r 6. Sex 7. Age (In yrs. last birthda 1	/) If Under 1 Year If Under 24 Hrs. 8. Date (Mon Months Days Hours Min. JAN	th, Day, Year) Country)
	and and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
	Maryl	tor	MD MONTGOMERY ROCKV	ILLE	1 Nes 2 □ No
	h the or 28a	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	23a c		3 OLD CREEK CT.	20854	USA
980	be filed within 72 hours after death with the Maryland Ital Hyglene. Id other than "natural", or Itams 23a or 28a-f show event, the Madical Examinational be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Notice Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☑ No Specify:	or No- c.) 14. Race - American Indian, Black, White, etc. Specify: WHITE
2	72 ho	eted		edent's Usual Occupation e kind of work done during most of working	16b. Kind of Business/Industry
21215-0036	e filed within al Hygiene. other than vent, the Max	Completed	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) ACHER	MONTGOMERY COUNTY PUBLIC SCHOOLS
Maryland	the filed nital Hyginad other	Be	17. Father's Name (First, Middle, Last) OLIVER COATSWORTH	18. Mother's Name (First, N ROSE LANG	Aiddle, Maiden Surname)
Z	2 should be and Mental Is markad (sumatic ev	2	19a. Informant's Name/Relationship (Type, Print) 19b. Ma	ling Address (Street and Number or Rural Route It	Number, City or Town, State, Zip Code) 2 2 4 0 1
	5 = 2 = 2		CHARLES DAVIS, JR / SON 1103	3-5 PRINCE EDWARD ST	FREDERICKSBURG, VA
Baltimore,	0 0			position (Name of ematory or other place) CCK CREMAT. 10/22/04	20c. Location - City or Town, State FREDERICK, MD
Balti	permit. Page Department of Important: If sny injury or once.		MILLIAM	22. Name and Address of Facility ILLTON FUNERAL HOME	ZIII ND 20838
(2)			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respirat	Approximate Interval Between
>	Physician		Immediate Cause (Final disease or condition	of sigmaid cal	Onset and Death Temoriths
	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0	
4		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
	cuted	Examiner	that initiated events C.		
90,	be executed sician and burial-transit	I Exa	resulting in death) Last Due to (or as a consequence of):		
68760,	physic	dlcal	d		
.O. Box (that the death certificate ed by the attending phys detached for use as the	Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
s, D.		by Ph	Part II. Dther significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
ords	w requires been sign should be	ted t	memeauf chionce de	aldel:	1 Yes 2 No 3 Probably 4 Unknown
of Vital Record	e law has b	Completed	Listany of atrial fibrel	721.4-0/1	Was an autopsy findings available prior to completion of cause of death?
ta	ician: Th certificate rector, pag	0	25. Was case referre to mulical	26. Place of Death Check	Yes 2 ØNo 1 ☐ Yes 2 ☐ No
<u></u>	S S	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	l ou	Residence 6 Other (Specify)
0 0	ding Ph th. After th funeral		27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	cribe how injury occurred
Division	Atten r dear ector	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Local City	tion (Street and Number or Rural Route Number, or Town, State)
Ω	Hospital or 24 hours afte Funeral Dir stely filled in I		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea		o the cause(s) and masser as stated
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s)
	To the h within 2- To the I complete	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			MAKabert Freschbartun	004165	October 21, 2004
			30. Name and address of person who completed cause of death (Ithm 23a) (Type III. ROBERT BIRSCHBACH, ML II.	64(THERSB	UNE MD 20877
5%	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature OCT 2 2 2004	& Sparks	

		1 - For State Registrar	State	of Maryla	and / Depa	artment of rtificate or	Health a f Death	nd Me	ntal Hygi	iene2 0 () 4	34958
Physic /Med		1. Decedent's Name (First, Midd SABEL F. DIO							Date of Death Month OCTOBER		Year 1	3. Time of Death 3:50 A M
Exam		4a. Facility Name (If not institution) Crofton Convale				4b. City, Town	or Location of	Death		4c. County of		undel
Funera Directo		5. Social Security Number 217-01-6160	6. Sex 1 □ M 2 X) F		rs. last birthday) Yrs.	If Under 1 Yea Months Day	r If Under 2	4 Hrs. 8 Min.	Date of Birth (Month, Day, 11–24–1	Year)	9. Birthp	place (State or Foreign
filed within 72 hours after death with the Maryland Hygiene. The man "natural", or items 23e or 28e-1 show out, the Mexical Examiner must be rediffed in	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Anne 10e. Street and Number 137 Southdown 11. Marital Status 1XX ever Married 2 Mar 3 Widowed 4 Divorced	Road 12. Was De Armed 1 1 Yes 1 Yes	cedent Ever in Forces?	1	Edgewa 10f. Zip Code 2103 Was Decedent of f Yes, specify Cu	37 f Hispanic Origi uban, Mexican,	in? (Speci Puerto Ri			- America, White,	ean Indian,
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", eny injury or other traumatic event, ite Musical Examples.	Completed			f) (1-4or 5+)	(Give	dent's Usual Occ kind of work don OO NOT use retii	ne during most (red)	·	I	6b. Kind of Bus Departme	ent s	·
y would be find the marked of matic even	To Be		l V. Dicke	3	10h 11-18-	Address (Char		Lic	la G. Ki	irby		
ss t and 2 sl of Health and ltem 27 is r		Lynda A. Walsh/	Niece	20b	137 Se	ng Address (Stree Outhdowr usition (Name of matory or other po	n Rd., 1		ater, N	-	7	
permit. Page Department of Important: If eny Injury or	i	1 □ Burial 2 ☒ Cremation 4 □ Donation 5 □ Other (5	Specify)	n State F	Kalas Cr	rematory Name and Add	10)–19–0 Geor		Edgewat Kalas Fu		
Coate be executed Physician and bhysician and the burial-transit		23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	equence of):	er the mode of d						Md . 21037 Approximate Interval Between Onset and Death week
t the death certifi by the attending ached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live 4 ☐ Pre 9 ☐ Unk		etal death 3 [f death 5 [Ectopic pregnan Other (specify)			23e. Did toba	23d. Date Mont	h	Day Year
	Completed by	21 1	eimen	/ \	eme,	rta		_	24a. Was an autopsy perform	24b. W	ere autor or to con ath?	psy findings available appletion of cause of
ng Physicien: fler this certific ineral director.	To Be	2 0 1 100 100 11	Hospital: 1 [28a. Dat (Mo	Inpatient 2 e of Injury enth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Inj	other: 4 Nurs	sing Home	Check only one 5 Resider Describe how	oce 6 □Other	(Specify	')
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Plai buil	ding, etc. (Spe	cify)	eet, factory, office			City or Town,	State)		l Route Number,
ths Hosp nin 24 hou the Funer	fedicai	one) P Medical		ne best of my ki basis of exami unner stated.	nowledge, death nation and/or inv	estigation, in my	opinion, death	place, and occurred	at the time, dat	te and place, ar	d due to	the cause(s)
To vith	×	29b. Signature and title of certific	Lly	-1 V	mD	D3	nse number 55845	7	- 1	d. Date signed $D/18$	Month, 6	Jay, Year)
S	tate	31. Date filed (Month, Day, Year,	Schaltz 32.	Reattrar's Sig	em 23a) (Type, 1438 nature	Deten	se Hu	7	Samb	rilly 4	nD.	21057
Regis		UCT '	1 9 71114	XI STARE	. A	throats ,		_				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 16, 2004 October Mary S. Ewell 10:40 a^M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Chesapeake Woods Center Cambridge Dorchester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F 058-16-9964 95 Director 22, 1908 Virginia Dec. Usual Residence of Decedent filed within 72 hours after death with the Marylan 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits tems 23a or 28a-f show r than "natural", or Items 23a or 28a-f show the Medical Examinations the conflict at 1 Pres 2 □ No Director Maryland Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 High Street 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 0. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ģ 3 ₩idowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Ladies Apparel 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health, and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event 900g. 18. Mother's Name (First, Middle, Maiden Sumame) Be James John Standing Marie Strobel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jefferson Hubbard/Grandson 102 High St., Cambridge, MD 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) 10/20/2004 | Church Creek, MD OldTrinityCemetery 21. Signature of Funeral Service Licensee Curran-Bronwell Funeral Home, P.A. 23a. Parti-Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 308 High St., Cambridge, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760. Physiclan/Medical attending pl 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death signed by the at d be detached fo 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ OSKOA CHICHS 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed 1 Yes 2 Wo 24b. Were autopsy findings available prior to completion of cause of death? has DISCASE death? (Kenson's of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Surrsing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29d. Date signed (Month, Daf, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NARK D.O. 1015 A 100 Brankole 2004 Registrar's Signature 31. Date filed (Month, Day Year) State Registrar

		_	
State of Maryland / Department of Health and Menta	l Hygiene	nni.	21
Certificate of Death		0.04	24

		1 - For State Registrar		Ce	rtificate of Dea	th and M	Re	g. No.		
Physic /Med	ical		Gibbons				2. Date of Death Month October	Day 25, 2		
Exam	ner	4a. Facility Name (If not institution, git	·		4b. City, Town, or Local			4c. County		
- Function		St. Mary's Nurs 5. Social Security Number 6.		(In yrs. last birthday)	Leonardto	nder 24 Hrs.	8. Date of Birth		Mary's	mian
Funera Directo			1 □ M 2 XX F	87 Yrs.	Months Days Hou	urs Min.	(Month, Day, July 16,	1917	9. Birthplace (State or Fo Country) Washington	
Maryland f show	jo	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Li 1 ☐ Yes 2X	
the 1	rect	Maryland Charl 10e. Street and Number	es	Bryanto	VII 10f. Zip Code		10	a. Citizen of V	Vhat Country?	
3a or	0	13925 North Sta	r Place		20617			U.S.A		
death ms 2	Jera	11. Marital Status	12. Was Decedent B	Ever in U.S. 13.	Was Decedent of Hispanio	c Origin? (Spe	cify Yes or No-	14. Rac	e - American Indian,	
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examinar must be natified at	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 🖫 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🛣N If Yes, Give Year or Dates:	lo		xican, Puerto F ecify:	Rican, etc.)	Specify	k, White, etc. White	
5-0 72 ho	ted	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occupation kind of work done during DO NOT use retired)	most of workin	10	6b. Kind of Bu	usiness/Industry	
Maryland 21215-0036 12 should be filed within 72 hours aft 12 and Mental Hygiene. 18 marked other than "natural", or 18 marked other than "natural", or resumatic event, the Medical Exami	Somple	Elementary/Secondary (0-12)	College (1-4or 5-	+)	DO NOT use retired) shier / Wait		9	Navy	Exchange	
nd he file	Be	17. Father's Name (First, Middle, Last)		18. M	łother's Name	(First, Middle, Ma	aiden Surnam	10)	
Maryland td 2 should be file th and Mental Hy t7 is marked oth traumetic event	To	Alfred Poitras					aomi (UN			
Par 2 sho and 1s my		19a. Informant's Name/Relationship			ng Address (Street and Nu	umber or Rural	Route Number,	City or Town,	State, Zip Code)	
of Health		Rita M. Chappe	11 / Daught				and the same of th		ryland 20617	
Baltimore, permit. Pages 1 ar Department of Heal mportant: If Item any injury or other and ince.		20a. Method of Disposition 1 ☐ Burial 2 Macremation 3 [1 4 ☐ Donation 5 ☐ Other (Speci		1	esition (Name of matory or other place)				City or Town, State tte Hall, MD	
Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Live	hspe			acility Br	insfield	Funer	al Home, P.A	•
		23a. Part1. Ent if the discrete, or conshock, or leart failer. List only	a ons that caused	the death. Do not ent		and the state of t			Approximate	
Physician		shock, or "eart failor". List only Immediate Cause (Final disease or condition resulting in death)		e to Thrive					Interval 8etweer Onset and Death	
/Medical Examiner		resulting in death)		consequence of):						
		Sequentially list conditions,	0.	ner's Disea consequence of).	ase					
ted 1sit	nine	Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	D00 10 (01 d3 e	consequence or,						
68760, tificate be executed ig physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
68760, ificate be exp physician as the burial	edical		d. =							_
= 0 a		IF FEMALE:								
Records, P.O. Box The law requires that the death cert ate has been signed by the attending age 2 should be detached for use a	Physician/N	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 1 9 Unknown	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date Mor	e of delivery oth Day Year	
rds, P.O.	by	Part II. Other significant conditions Vaginal Bleed:		t not resulting in the u	nderlying cause given in P	art I.			ibute to the cause of death	
If Records, The law requires the law requires the last been signed page 2 should be considered.	Completed		-				24a. Was an autopsy performe 1 Yes 2	. I n	Vere autopsy findings availation to completion of cause eath?	able of
	e C	25. Was case referred to medical			20. 5	Place of Doort	1 Yes 2 (Check only one)		Yes XXNo	
	O B	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 Inpatier	nt 2 ER/Outpatien			e 5 🗆 Residen		or (Conneit)	
	\vdash	27. Manner of Death 1 X Natural 5 Pending	28a. Date of Injury (Month, Day	y 28b. Time of		28	3d. Describe how			
Division or Attending after death. Director: After	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	OD Disease laiv	ry - At home, farm, str . (Specify)		-	Bf. Location (Stre City or Town, .		or Or Rural Route Number,	
Hospite 24 hours Funeral	edical C	29a. Certifier (Check only one) 1 Certifying Pl 2 Medical Exa	nysician: To the best of miner: On the basis of and manner state	examination and/or in:	n occurred at the time, date vestigation, in my opinion,	e and place, ar death occurred	nd due to the cau d at the time, date	se(s) and mar and place, a	nner as stated. nd due to the cause(s)	
To the within To the comple	Me	29b. Signature and title of certifier	2 M	D	29c. License numb	ber	29d		(Month, Day, Year)	
		No. No. of Address of A	Υ)	,	D56261			10-27-	-04	

State Registrar Archana Gupta, M.D.

31. Date filed (Month

DHMH 17 Rev 1/2001

24035 Three Notch Road Hollywood, Maryland 20636

State of Maryland / Department of Health and Mental Hygien [] 34961 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year Go 10/19/2004 4:25 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Southern Maryland Hospital Center Clinton Prince George's 5. Social Security Number 219-31-2016 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/16/1920 Funeral Birthplace (State or Foreign Country) 1XXM 2□ F Months Days Hours Min Director 84 China Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importent: If item 27 Is marked other then "naturel", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Experiment 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Ft. Washington 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Kerby Hill Road 20744 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2171No Yes, Give 1 ☐ Yes 2 ☐ No Specify: Asian þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Specify. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Self-Employed Entrepreneur 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOWN Go Kim Chua 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aurelia Go / Wife 100 Kerby Hill Road Ft. Washington, MD. 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State KXBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 10/25/2004 Clinton, Maryland 21. Signature of Funeral Sorvice Live see 22 Name and Address George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** pneummia week /Medical due to (or as a consequence of): **Examiner** Congestive heart I week. Sequentially list conditions, if any, leading to immediate case. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed the burial-transit Roud Due to (or as a consequence of): P.O. Box 68760, IF FEMALE for use 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Be Completed 1 ☐ Yes 2 💆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 Unpatient 2 ER/Outpatient this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DQA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending nours after death.

nerel Director: Aft

filled in by the fur investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3(206 address of person who completed cause of death (Item 23a) (Type, Print) Livingsom Road For WASHINGTON 111/00 11701

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2 1 2004

			1 - For State Registrar		State o	of Maryla		artment of rtificate o			lental Hygi	e2e()	04	349	962
	Dhysis		Decedent's Name	(First, Middle,	Last)						2. Date of Death Month		Yeer	3. Time	e of Death
	Physici /Medi		Jacquelin								October	25	2004	12:	:25 A M
	Examir	ier	4a. Fecility Name (If I						n, or Location	of Death		nty of Death			
			8202 Blue 5. Social Security Nur		Drive #3		a look blak to	Freder If Under 1 Ye		24 Ura			ederi		
No.	Funeral Director		162-20-369 Usual Residence of D	94	1 M 2 X F	7. Age (in yr.	s. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthple Country January 6, 1927 Pennsy					plece (Staintry) Sylva	te or Foreign ania	
	land ow			10b. County		10c. C	City, Town or L	ocation						10d. Inside	City Limits
	Mary I-f eh	ţō	Maryland	Freder	ick	Fre	ederick								'es 2 □ No
	h the	lrec	10e. Street and Numb	per				10f. Zip Code	е		10	g. Citizen o	f What Cou	ntry?	
	th wit	alD	8202 Blue	Heron 1	Drive #1	A		2170	1			U.S	.A.		
	r dea	Funeral Directo	11. Marital Status		12. Was Dec	edent Ever in orces?	U.S. 13.	Was Decedent of	of Hispanic Ori	igin? (Spe	ecify Yes or No-		ace - Americack, White,		1
36	s afte , or if	by Fu	1 ☐ Never Married 3 🏋 Widowed 4		If Yes, Gr	ve		1 □ Yes 2 😾 N		.,			ify: Whit		
ခု	hour fural	ed b		5. Decedent's	Year or D	ates:		dent's Usual Occ							
15	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f ehow attic event. The Medical Examiner must be notified at	Completed	(Specify	only highest g	rade completed)	4.4	(Give	kind of work doi DO NOT use ret	ne durina mos	t of worki	ng 18	D. Kind of	Business/In	dustry	
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<u>×</u>	should bind Ment marked umatic	To	John Cham	bers Ge	orge						. Lawghea				
lar ·	is 1 and 2 should if Health and Meritem 27 is merke other traumatic		19a. Informant's Nam								l Route Number, (
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وَ	Pages nent of h int: If its		1 🗆 Burial 2 🔀	Cremation 3		State	cemetery, crei	matory or other p	place)				· City or To		
Baltimore, Maryland 21215-0036	permit. Pages Department of Important: If it eny injury or o		* 4 □ Donation 5			Sn		rg Crema 2. Name and Add			/2004				yland
Ba	Deported Park		PR	100 7	10 mill	10				•	Tuneral Hon				h Street
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	Physician		Immediate Cause (Fi	ialiure. List on	y one cause	Laur	stem	alio	mus				0	Interval B Onset an	
	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):	0						1	
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Вох	death certific le attending pl ed for use as t	lan/	23b. Was decedent p			irth 2 ☐ Fet	al death 3	Ectopic pregnan	псу				ate of delive		Wasa
	0 0 0	ysic	1 ☐ Yes 2 ☑ 1 9 ☐ Unknown		4☐ Pregn 9☐ Unkno	ant at time of	death 5□	Other (specify)				IM	oritri	Day	Year
P.0	requires that the deen signed by the		Part II. Other significa	ant conditions	contributing to de	eath but not re	sulting in the u	nderlying cause o	oven in Part I.		23e. Did tobac	co usa con	tribute to th	e cause of	f death?
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Re	tici an: The lav certificate has rector, page 2	Completed									autopsy performe	120	Were autor prior to con death?		cause of
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0 U	ng Ph Iter th		27. Manner of Death	5 Pending	28a. Date of	of Injury h, Day Year)	28b. Time of	28c. In			8d. Describe how			/	
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Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	determine	280. Place	of Injury · At h	nome, farm, stre	et, factory, office	Э	2	8f. Location (Stree City or Town, S	t and Numi	ber or Rural	Route Nu	mber,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only one) 2[Medicel Exa	miner: On the ba and mann	isis of examina	owledge, death ation and/or inv	occurred at the estigation, in my	time, date and opinion, death	place, an	nd due to the caus d at the time, date	e(s) and m and place,	anner as sta and due to	ited. the cause	(s)
	o the	Me	29b. Signalure and title	e of certifier	273 77211	or stated.		29c. Licer	nse number		29d.	Date signe	d (Month, D	Dav. Year)	
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_			20. Na e and address	of person who	completed cause	e of death (Iter	m 23a) (Type, I	Print) A	- 111			_10,7		، هي م	
_	13		HIEN J.	61 SON	no	1475	TANE	1 HE	FRE	DA	少 21	202			
1	Sta	е	31. Date filed (Month)	Day Year)	2001 32. Re	egitrar's Signa	ature	-	E 4						
	Registra	II I	. 10	V I (-UU4 R	Janes Marie	19								

Registrar DHMH 17 Rev 1/2001 R.T

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 2004 34963 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** October 14, 2004 HARPER RONALD 12:10 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 6. Sex 12 M 2□ F If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Par 10, 1984 Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Months Hours Min 213-21-5461 20 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23e or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐Yes 2 ☐ No Director MD Prince George Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 U.S.A. 2729 Hawthorne Terr 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: № Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) I.B.E.W. Electrician 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be it thent of Health and Mental I tent: If item 27 Is marked o Janette Awkard Ronald Harper, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janette Awkard- Mother 2729 HAWTHORNE TERR Landover, MD 20785 other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/19/04 Alexandria, VA Metro Fnl Svcs ` 4 □ Donation 5 □ Other (Specify) permit.
Departr
Importe
any inju 2). Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N Washington St Rockville, MD20350 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician a GUNSHOT WOUNDS (TWO) TO TOKIO /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (cr as a consequence of) death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) P.O. detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1-2 Yes 2 \sum No autopsy performed? 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division Hospital or Attending 5 Pending investigation 1 Natural Injury SUBJECT WAS SHOT death. 6:11 PM 10/13/04 1 Tes 2 No 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4X Homicide 7317 LANDOVER ND, MD OUTSIDE RESIDENCE within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year) MUST OCME October 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print ANA RUBIO, MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

OCT 21 2004

32. Registrar's Signature

Sparker

			1- For Amend Items 28	State of Maryland (Depa Bb, I per ME, G838, L2 Cei		Mental Hygie		34964
1	Physic	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	_	3. Time of Death
	/Medi		Douglas Claude Hay			Oct. 19,	2004	5:30 PM
die	Exami	ner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deatl	1	4c. County of Death	
		*	30050 Huntt Road 5. Social Security Number 6. Sec	y 7 Ann /le une la chiefe i A	Mechanicsville		St. Mar	
п	Funeral Director		226-26-0531	7. Age (In yrs. last birthday) 83 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthp	lace (State or Foreign try) York
			Usual Residence of Decedent	03		butte 9, 1	921 New	York
	hours after death with the Maryland turel', or Items 23e or 28a-1 show at Examinational by availated at	_	10a. State 10b. County	10c. City, Town or Lo	cation		10	0d. Inside City Limits
	e Ma Sa-1 s	cto	Maryland St. Mary	s Mecha	nicsville			1 ☐ Yes 2 ☐ No
	ith th	Funeral Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	s 23e	ral	30050 Huntt Road		20659		USA	
	ter dea	une		12. Was Decedent Ever in U.S. Amned Forces?	Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - America Black, White, e	
336	urs aff	by	1 ☐ Never Married 2 ☐ Married ☐ 3 【 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates: 1944-46	I ☐ Yes 2 ☑ No Specify:		Specify: Whi	t.e
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yla	2 should be filed withir and Mental Hygiene. Ie marked other then eumatic event, I'm Me	မ	Lloyd Finch Hayes				aret Eifle	
Maryland	is 1 and 2 should be filed withing Hygiene. If Health and Mental Hygiene. Item 27 le marked other then other treumatic event, Ins. M.		19a. Informant's Name/Relationship (Ty		g Address (Street and Number or Ru			Code)
	of Health item 27 other tr		Douglas M. Hayes -	Son 1/744 20b. Place of Dispos	Ryland Chapel, R			
ğ	0	'	W Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemetery, crem	natory or other place)		. Location - City or Tov	
Baltimore,	permit. Pag Department Important: I eny injury o		' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licers	MOOOE 2	Veterans' Cem 10-	25-04 Che	eltenham, N	4D
Ba	permit. I Departm Importar eny inju		March 4 Breek		Name and Address of Facility ntt Funeral Home			
	7		23a. Part1. Enter the disease, or compli	cations that caused the death. Do not enter	0. Box 156, Wald	orf, MD 20	0604-0156	Approximate
	Physician		Immediate Cause (Final	ne cause on each line.		, , , , , , , , , , , , , , , , , , , ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequence of):				
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	p =	iner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury	Qualto (or as a noneaquance of):				
	and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last					
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9 x	death certifica attending ph d for use as ti	Physiclan/Me	IF FEMALE:	3c. If yes, outcome of pregnancy				
Вох	atten for u	clan	in the past 12 months?	1 Live birth 2 Fetal death 3 □I	Ectopic pregnancy Other (specify)		23d. Date of delivery Month	y Day Year
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٩.	The law requires that the death certificate tee has been signed by the attending physioage 2 should be detached for use as the face that the f		Part II. Other significant conditions con	tributing to death but not resulting in the unc	derlying cause given in Part I.	23e. Did tobacc	o use contribute to the	cause of death?
rds	quires n sign ald be	9					2 □ No 3 □ Probat	
00	sw require s been sign	Completed				24a. Was an	24h Were autons	sy findings available
R	The la te ha age 2	шо				autopsy performed:	prior to comp death?	pletion of cause of
		a)	25. Was case referred to medical		26 Place of Deat	1 Yes 2	No 1 □ Yes 2	No
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n of	ding Ph		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of		28d. Describe how in		
sio	tendi eath. or: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	10-18-04 6700	M 1 ☐ Yes 2 No	SelF IN	Muchal.	65W.
Division	or At fter d Sirect in by	Certification;	4 Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street City or Town, Sta	and Number of Rural F to) 30050 Hur	Route Number,
	pitel ours a erel [200 Continue 1 Continue Division Divisi	1 time		-14	Mechan	nicsville
	Hos 24 hc Fun stely (edical	29a. Certifier 1 ☐ Certifying Phys: (Check only one) 2 Medical Examin	icien: To the best of my knowledge, death of er: On the basis of examination and/or investigation	occurred at the time, date and place, estigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stat nd place, and due to th	ed. MD
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer		29b. Signature and title of certifier	and manner stated.	29c. License number		ate signed (Month, Da	
	⊢s⊢ó) Inda	tam	014285			
(+	30. Name and address of person who con	npleted cause of death (Item 23a) (Type, P	.0	- (0-21-0	Υ
1	B16=1		Dr. William Boyd.	25365 Point Lookout	Road, Leonardtow	n. MD 2061	50	
	Sta	te	31. Date filed (Month, Day, Year)	32 Relistrar's Signature	Econaracow	בווי בווי בווי) U	
IE	Registra	ar	001 7 I (0	04 Jours It A	340			

Registrar	nd / Department of Health Certificate of Deal	n R	eg. No.	5
Physician /Medical 1. Decedent's Name (First, Middle, Last) WILLIAM E. HUDSON		2. Date of Deat Month	th Day Year 3. Time of Do	
Tivedical Examiner 4a. Facility Name (If not institution, give street and number) Continue Properties	Marcha Dave Harris	on of Death	4c. County of Death	oreign
Usual Residence of Decedent	ity, Town or Location		10d. Inside City	Limits
DELAWARE SUSSEX	SELBYVILLE		1 \(\text{Yes 2} \)	
DELAWARE SUSSEX S 10e. Street and Number 317 PEAR TREE LANE	10f. Zip Code 19975	1	0g. Citizen of What Country? US	
11. Marital Status 12. Was Decedent Ever in U. Armed Forces?			14. Race - American Indian, Black, White, etc. Specify: WHITE	
The state of the s	16a. Decedent's Usual Occupation (Give kind of work done during m life. DO NOT use retired) SELF EMPLOYED PAI	ost of working	16b. Kind of Business/Industry HOUSE PAINTING	
Tr. Father's Name (First, Middle, Last) 17. Father's Name (First, Middle, Last) ELISHA WALTER HUDSON	18. Mo	ther's Name (First, Middle, A		
19a. Informant's Name/Relationship (Type, Print) CARYN DUNCAN/ DAUGHTER	19b. Mailing Address (Street and Num PO BOX 724, SELBY			
20a. Method of Disposition 1 Burial 2 © Cremation 3 Removal from State 1 Burial 2 © Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fureral Service Licensee	Place of Disposition (Name of CSON SECRET CAPE OF HENCOPE	Date 2	20c. Location - City or Town, State	
21. Signature of Furgrand Service Licensee	EMATORY 22. Name and Address of Fa MELSON FUNERAI THATCHER STREE	cility	FRANKFORD, DELAWARE	
23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. Let only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or as a consequence of the conditions).	th. Do not enter the mode of dying, such	as cardiac or respiratory arre	Approximate Interval Betwee Onset and Dec 3 week	ath
The part of the past 12 months? Due to (or as a consequence of the past 12 months? Due to (or as a consequence of the past 12 months? Due to (or as a consequence of the past 12 months? Due to (or as a consequence of the past 12 months? Due to (or as a consequence of the past 12 months?) Due to (or as a consequence of pregnant 1 Live before 1 1 Live before 1 1 Live before 2 1 1 Live before 2 1 1 Live before 3 1	quence of):			
Attending to the set of the set o	al death 3 □Ectopic pregnancy		23d. Date of delivery Month Day Yea	r
w. reduines the people of the	sulting in the underlying cause given in Pa		pacco use contribute to the cause of deat is 2 \(\text{No} \) 3 \(\text{Probably} \) Probably \(\frac{4}{2} \) Unk	
Attanding Physician accords. Attanding Physician The law requires to safe the sammer? The part of the part of the part of the sammer? Solution of Attanding Physician The law requires to sammer? The part of the part of			y prior to completion of caus death? No 1 □ Yes 2 No	ilable e of
25. Was case referred to medical examiner? 1	04	ce of Death <i>(Check only one</i> Nursing Home 5 \(\subseteq \text{ Reside} \)		
27. Manner of D ath 28a. Dife of Injury - At ho 27. Manner of D ath 28b. Dife of Injury - At ho 27. Manner of D ath 28b. Dife of Injury - At ho 28b. Place of Injury - At ho 2b. Place of Injury - At ho 2b. Place of Injury - At ho 2b. Plac	28b. Time of Injury at Work? M 1 □ Yes 2	28d. Describe ho		
	ome, farm, street, factory, office	28f. Location (Str City or Town	reet and Number or Rural Route Number , State)	
Ce ed ed ed ed ed ed ed ed ed ed ed ed ed				
Some the state of the best of my known one) 29a. Certifier Certifying Physician: To the best of my known one) Medical Examiner: On the basis of examinate and manner stated and manner stated.	owledge, death occurred at the time, date atton and/or investigation, in my opinion, d	and place, and due to the ca eath occurred at the time, da	use(s) and manner as stated. .te and place, and due to the cause(s)	
29a. Certifier 12 Certifying Physician: To the best of my know (Check only (Ch	owledge, death occurred at the time, date ation and/or investigation, in my opinion, d	eath occurred at the time, da	ause(s) and manner as stated. Ite and place, and due to the cause(s) Od. Date signed (Month, Day, Year)	
29a. Certifier 1 Certifying Physician: To the best of my known one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item	29c. License numbe	eath occurred at the time, da	ite and place, and due to the cause(s)	2,

Hucken, William inhelof 1100 to

State of Maryland / Department of Health and Mental Hygien 2004 34966 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day October 24 **Physician** Marie Elizabeth Hofe 2004 4:02 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeders Memorial Home Washington County Boonsboro If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2 F Days 219-12-2097 83 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits item 27 is marked other then "natural", or itams 23s or 28e-1 show other traumatic avent, the Mydical Exart as must be prolified at 1 ☐ Yes X☐ No Maryland Washington Hagerstown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 165 Southern Oak Drive 21740 U.S.A. Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ☐ Yes 2 X No Yes, Give 1 ☐ Never Married 2X Married 1 ☐ Yes 2 ☐ No Specify: White Maryland 21215-0036 Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Victor Shaw Nancy E. Kline 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 165 Southern Oak Drive Hagerstown Maryland 21740

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Kenneth E. Hofe (Husband) Baltimore, 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State ö permit. Page Department of important: If any injury or once. Rest Haven Cemetery 4 □ Donation 5 □ Other (Specify) Oct 27 04 Hagerstown Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 2) Signature of Funeral Service Licenses Jouglas Q. Jury 1331 Eastern Blvd. N. Hagers

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1331 Eastern Blvd. N. Hagerstown Maryland 21742 Approximate Interval Between Onset and Death mmediate Cause (Final Physician Phennanie Zelon disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transit Due to (or as a consequence of): 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Seizu Din mallita 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Alghermen 24a. Was an certificete has I rector, page 2 s 2 210 1 Yes Hospital or Attending Physiclan: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 2 NO 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in 24 hours a Funerai 29a. Certifier 1 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai within 24 ho To the Function 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18019 OCTOBER 24, 2004 -Onte MO 3H-2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street Hagerstown, MD 21740/ 301-739-7100 Vasant Datta 340 Mill 32. Registrar's Signature State OCT 26 2004 Gertal Malin Registrar

		•	For State Registrar		State of Ma	aryland / i	Depa <i>Cer</i>	artment of H tificate of I	lealth Death	and M		gie j e Reg. No.	0 0 1	349	67
			1. Decedent's Name	(First, Middle, La	ist)	-					2. Date of Dea	ith Day	v Year	3. Time	of Death
	Physicia /Medic		Evelvn	Doretha	Harris								2004	9:55	5 Р ^м
	Examin				e street and number)			4b. City, Town, or	Location	of Death			County of Dea	th	
			Clintor	n Rehabi	litation			Clinton	n			Pr	ince Ge	eorge	
	Funeral		5. Social Security Nu		I THE OFFICE	e (In yrs. last bii		If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birtl (Month, Day	Year)	9. Bin Co	thplace (State	or Foreign
	Director		577-50-63	0/3	1 N 2 A	39	Yrs.				Apr. 25	, 19		shingto	
	and w	}	Usual Residence of 10a. State	10b. County		10c. City, Tow	m or Lo	cation						10d. Inside (City Limits
	Manyl f sho	5	MD	Prince (George	Lanha	am							17 Ye	s 2□No
	the 28a-	Director	10e. Street and Nur					10f. Zip Code				10g. Citi	izen of What Co	ountry?	
	with 3a or			reenbelt	Road			20706					USA	•	
	death rns 2;	Funerai	11. Marital Status	CCIDCIC	12. Was Decedent	Ever in U.S.	13.	Vas Decedent of H	ispanic O	rigin? (Spe	cify Yes or No-		14. Race - Ame		
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hyglene. Item 27 is marked other than "natural; or items 23a or 28a-f show other traumatic event, the Modeal Examination into the notified at	by Fur	1 Never Marrie 3 Widowed	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No		f Yes, specify Cuba □ Yes 2🌠 No	Specify		Rican, etc.)		Black, White Specify: B]	•	
Ö	72 ho	Completed	(8-00)	15. Decedent's E		16a	. Deced	lent's Usual Occupa kind of work done of	ation	set of worki	20	16b. Ki	ind of Business	/Industry	
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2	er than	Con	12			Su	ıper	visor Sta					easurer	Dept.	
nd	ba filed tal Hygid d other event,	Be	17. Father's Name (t)						(First, Middle,	Maiden	Sumame)		
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ar	and and is my	0. 7	19a. Informant's Na					g Address (Street a							
	Health tem 27 other tra			Tamilton/	Cousin			Lockerby	/ Ct.						
altimore,	Page nent o ant: if ury or				□Removal from State	cemete	ny, cřen apea	sition (Name of natory or other plac k Cremato	ory	10/22	•	Be	eltsvill	e, MD	
alt	permit. Departr Importa any inju		21. Sign rivre of Fu	neral Service Lice	nsee		100	. Name and Addres		-					s
8	20199		UX.	W. XC	1 Klant			500 Aller				·	gs, MD	20748	
	Physician		Immediate Cause (Final	nplications that caused one cause on each li	the death. Do ne. 2 hoins	not ent	er the mode of dyin	g, such a	s cardiac o	r respiratory ar	est,		Approxima Interval Be Opset and	etween
	/Medical		disease or condition resulting in death)	n /	Doe to of as	a gonsequence	of):	1	100	1 -	Januar			1 8 20	VIAL
	Examiner			. 191		Mon	ü	Miselt	m/h	u l	Januar	N	_	1 W	/
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9	entific ling p	0 1	IF FEMALE:		00 - 1/										
Вох	The law requires that the death certific tte has been signad by the attending to page 2 should be detached for use as	Physician/M	23b. Was decedent in the past 12	months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)				1	23d. Date of del Month	ivery Day	Year
o.	at the de by the a tached f	ıysi	1 ☐ Yes 2 ☐ 9 ☐ Unknown	JNo	9□ Unknown			, Go. (Gp. G)/							
٥	that and by deta		Part II. Other signifi	icant conditions	contributing to death b	ut not resulting i	in the u	nderlying cause givi	en in Part	1.	23e. Did to	bacco u	ise contribute to	the cause of	death?
Sp.	uires signi	d by	1								1 🗆 Y	es 2	No 3□Pr	obably 4]Unknown
2	w requir been si should	iete									24a. Was a	ın	24b. Were au	itopsy findings	s available
Records,	The lavate has	Completed								-	autop perfor	sy med2	prior to death?	completion of	cause of
Vital		C	25. Was case refer	red to medical	1				26 Plac	se of Death	1 Yes	2 🛮 No	1 LJ Yes	2 🗌 No	
>	Physician; this certific ral director,	OB	examiner? 1 ☐ Yes 2 ☑	/	Hospital:	ent 2 ER/O	utpatien	t 3 DOA Cthe		/	ne 5 Resid		6 ∏Other (Spe	cifv)	
of		L.	27. Manner of Death		28a. Date of Inju (Month, Da	ıry 28b.	Time of	28c. Injury	at at		28d. Describe h				
Ö	nding lath. Ith. :: After e funer	atio	1 ✓ Natural 2 ☐ Accident	5 Pending investigation		y (eat)	Injury	World M 1 □	Yes 2	No					
Division	Attendil rr death, ector: A by the fu	ifica	3 ☐ Suicide 4 ☐ Homicide	6 Could not I determined	289. Place of Inj	ury - At home, fa c. (Specify)	arm, str	eet, factory, office		2	28f. Location (S City or Tow			ıral Route Nui	mber,
ā	tal or Attendii s efter death, al Director: A ad in by the fu	Certification;	+ Li Homicido		building, et	c. (Specify)					Only or row	ii, otate,	/		
	To the Hospital or Attending within 24 hours efter death, To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier (Check only one)	1 Certifying P 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination ar	e, death	occurred at the time restigation, in my op	ne, date a pinion, de	and place, a eath occurre	and due to the ded at the time, o	ause(s) late and	and manner as I place, and due	stated. to the cause((s)
	To the within 2 To the complet	Me	29b. Signature and	title of certifier				29c. License	number		- 3	9d. Dat	e signed (Mont	h, Day, Year)	
			16		2			D-6	245	35		10	21.04	1	
D	(2)		30/Name and address	ess of person who	completed cause of c	leath (Item 23a)	(Туре,	Print)	-			-	0.500000000		236
1	9		LEXIN		rwa 7	700 C)ld	Branch	1 Ar	re, A	C/01	U	infor.	mo de	0133
	Sta		31. Date filed (Mont	th, Day, Year) 2 1 200	2. Registr	ar's Signature	-								
	Registi	ar	UCI	2 T ZUU	" Blown	No 1	Jan	W							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiepen 🛭 📗 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Dorothy Holtom 12:45pm'October 19, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b City Town or Location of Death 4c. County of Death **Examiner** Shady Grove Nursing & Rehab Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Months Days Hours 1 M 2 X F Director 334-09-2694 86 06/03/1918 unk. Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits r items 23a or 28e-f show ther must be notified at 1 X Yes 2 □ No Director Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701 Medical Center Drive 20850 death U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Item any injury of wher treumatic event, the Medical Exercises. Black, White, etc. 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White þ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unk. unk. unk. 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk. unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 305, West Friendship, Maryland 21794 Ria Rochvarg, Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Ft. Lincoln Crematory 10/25/2004 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) <u>Dementia</u> vears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) the (9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Munknown Stroke Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coronary Artery Disease certificate has page 2 autopsy perform 1 ☐ Yes 2 💢 No Hospitel or Attending Physicien: 24 hours after death. Funerel Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 😿 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 1 Natural 2 Accider 5 Pending investigation Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 7.24 hour. 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 2 To the I and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)
OCT 2 1 2004 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. Mendhiratta, MD 2401 Research Blvd, ste 330, Rockville, MD 20850 32 Registrar's Signature DOCKA

MD

D38262

October 20, 2004

State of Maryland / Department of Health and Mental Hygieren

						Ce	rtifica	te of	Death		Reg. No.	4 31	כסכו
			1. Decedent's Neme (First, Middle	e, Last)						2. Dete of D	Peeth		. Time of Death
	Physician	-	Claude	Herbert		Hine	baug	h		Octobe	Dey er 21	Year 2004 1	1:35 AM
	/Medica Examine		4a Fecility Neme (If not institution			11,211	-Duug		4b. City, Town, or			y of Death	ביוא כנייב
	LAGITITIC		307 Calderwood	Road					Deer	Park	G	arrett	
-	Funeral		5. Social Security Number		e (In yrs. le	est birthdey		er 1 Year	If Under 24 Hrs	8 Date of B	irth		(State or Foreign
ħ.	Director		212-24-0984	1 ☑ M 2 □ F	76	Yrs.	Months	Days	Hours Min		Dey, Year) 8, 1928		
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	ylan		10a. State 10b. County		10c. City	, Town or L	ocation						Inside City Limits
	Mar	2	MD	Garrett			D	eer :	Park			1	1 ☐ Yes 2 🙀 No
	r 28	Director	10e. Street end Number				10f. Z	ip Code			10g. Citizen of	Whet Country?	
	within 72 hours after death with the Maryland ene. than "natural", or itema 23s or 28s-f show he Madical Examiner must be notified at	=	307 Calderwood	Road					21550			USA	
	deati	Laurera	11. Maritel Status	12. Was Decedent	Ever in U,	S. 13.	Was Dec	edent of I	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N	lo- 14. Ra	ce - American Ir	ndian,
ယ	in the state of th	2	1 Never Merried 2 Marr	Armed Forces?	No					to moan, etc.)			
93	alf, o	<u> </u>	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			I LI Yes	21 No	<i>эрвспу:</i>		Speci	ήν: Whi	te
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2	d with	5	7 t h			Farr	ner/C	oal l	Miner		Farmin	g/Coal	Mining
Þ	office and office and	90	17. Fether's Neme (First, Middle,	Last)					18. Mother's Na	me (First, Middi	le, Maiden Suma	me)	J
<u>a</u>	fenta fenta fenta fenta fenta	2	Robert W	hite H	ineba	augh			Minnie	Н	elen	King	
ar.	12 should be filed within h and Mental Hyglene. I a marked other than 'traumetic event, the Mental Hyglene.	-	19a. Informant's Name/Reletions	hip (Type, Print)		19b. Mail	ing Addre	ss (Street	and Number or R	ural Route Num	ber, City or Town	, Stete, Zip Coc	de)
Σ	r tra		Claudia Shaffe	r/daughter		307	Cald	erwoo	od Road,	Deer Pa	ark. Mar	vland 2	1550
ē,	s 1 and 2 I Haalth tem 27 I	ŀ	20a. Method of Disposition		20b. PI	ace of Disp	osition (N	ame of		Date		- City or Town,	
9	age anto ft: If I		1 XBurial 2 ☐ Cremation 4 ☐ Donetion 5 ☐ Other (S							10/2//0	D	D 1 1	1 . 1
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within Department of Haalth and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Manage.	ŀ	21. Signature of Funeral Service		рее	er Par			ess of Facility	10/24/0	4 Deer	Park, M	Maryland
Ba	Deperment of the party of the p		D. D.	11 12			Stew	art]	Funeral H	Home			
		4	11 Myses	- Heller X		5	32_S	. Se	cond St.	, Oaklar	nd, Md.	21550	
			23a. Pert1. Enter the diseese, or shock, or heart failure. List	only one cause on each li	the death ne.	. Do not er	iter the mo	ode or dyli	ng, such es cardia	ic or respiratory	arrest,	Inte	proximate erval Between eset and Death
	Physician												so, and south
	/Medical Examiner		Immediate Ceuse (Final disease or condition resulting in death)	e_Arterio	scle	rotic	Card	iovas	scular_D:	isease		imm	ediate
			resulting in ceatin		Due to (or	as a conse	equence of	f):					
	pa #			b									
	The law requires that the death certificata be executed at has been signed by the attending physician and paga 2 should be detached for usa as the burial-transit	Z Z	Sequentially list conditions,		Due to (or	es e conse	quence of):					
68760,	clan		Sequentially list conditions, if eny, leading to immediete ceuse. Enter Underlying Ceuse (Disease or injury	c									
87	ata physi the	edical	that initieted events resulting in death) Lest		Due to (or	as e conse	quence of):					
9	ing pa as	Σ		d								Ē.	
Box	attendi I for usa			- 0									
	he a	2	Part II. Other significant condition	ns contributing to death b	ut not resu	Iting in the	underlying	cause giv	ven in Part I.	23b. Di	d tobacco use c	ontribute to the	cause of death?
P.0	that the de led by the a detached	ruysician	cerebrovascul	ar accident						10	Yes 2√2 No	3 Probabl	y 4 🗆 Unknown
	es tha igned be de	2		-								T	
Vital Records,	v require been si should I	Completed									is an autopsy formed?	availab	eutopsy findings ole prior to
ပ္ထ	s be	2										of deet	etion of cause th?
ď	ysician: The law ils certificata has I i director, paga 2 s	5								1 🗆	Yes 2⊠No	1 □ Ye	s 2 No
tal			25. Was cese referred to medica						26. Place of De	ath (Check only	one)		
>	Physician: this certific ral director,	5	examiner? 1 ☑ Yes 2 ☐ No	Hospital:	ent 2 🗆 I	ER/Outpetie	ent 3□ [DOA Oth	ner: 4 Nursing I	Home 5⊈Re	sidence 6 □Ot	her (Specify)	
O 5 5 9 137 Manner of Death 28e Date of Injury 28h Time of 28c Injury at 28d Describe how injury occurre								rred					
Ö	th. : Afte	2	1 Selecturel 5 ☐ Pending 2 ☐ Accident investig	9	y roar)	Injury	М		Yes 2 □ No				
DivIsion	Attar dea oy th	27. Menner of Death 1 SNeturel 2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, ferm, street, factory, office 28f. Location (Street and Num City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office 28f. Location (Street and Num City or Town, Stete) 28d. Describe how injury occu Work? 1 Yes 2 No 28d. Describe how injury occu Work? 2 No 28d. Describe how injury occu							iber or Rurel Ro	oute Number,			
ă	din Die		4 Li Homicide	building, et	c. (Specify)				City of 1	Own, Steley		
	To the Hospital or Attanding F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	<u>ا ج</u>		g Physician: To the best									
	Hotely	a colical		Examiner: On the basis o and manner st	f examineti								
	of the	Σ	29b. Signature end title of certifie	r			2	9c. Licens	se number		29d. Date sign	ed (Month, Dey,	, Year)
	- > - 0		1/4/					D	2721	05	10/21/2	004	
7	10	-	30. Neme end eddress of person	who completed cause of a	looth /Itam	23e) (Tuno	Print\		010				
	U		Karl E. Schw			Four		tree	t Oaklar	nd, MD	21550		
			31. Date filed (Month, Day, Year)										
	State		OCT 2	5 2004	- 3	ala	A)	. 40					

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			ForStete	State of Maryl				lental Hygier	2004	34970
			Registrar	not!	Cer	tificate of L	Jeath	Reg. N		3. Time of Death
	Physicia	an	1. Decedent's Name (First, Middle, La	tarris				Month D	ay Year	1915 M
	/Medic		4a. Facility Name (If not institution, gire	ve street and number)		4b. City, Town, or	Location of Death		c. County of Deat	
	Examili	Ç.	Dorchester (Jerosal 1	1-teip	Camb	ridge		Derch	ester
Ī	Funeral Director		214-07-9245	Sex 1 1 1 2 F 7. Age (In)	yrs. last birthday) 74 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea May 13, 1	9. Birt 9/0 Mo	hplace (State or Foreign untry) LYY/and
	and		Usual Residence of Decedent 10a. State 10b. County	10c	: City, Town or Lo	cation				10d. Inside City Limits
7	be filed within 72 hours after death with the Maryland stal Hygiene. dother than "natural", or items 23a or 28a-f show event, the Medical Evanities must be notified at	to	MD Dor	chester	Can	1bridg	e			1 PYes 2 □ No
2	h the or 288 ercul	Director	10e. Street and Number		10.00	10f. Zip Code		10g. (Citizen of What Co	untry?
7	23a c	raiD	520. Gler		venue	2/0	6/3		USA	
	er dez	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13. \	Was Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
36	irs aft		1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	If Yes, Give Year or Dates:		I□Yes 212 No	Specify:		Specify:	.c.K
5-0036	2 hou	Completed by	15. Decedent's E	ducation	16a. Deced	ient's Usual Occupa	ation	ina 16b.	Kind of Business/	
2	ithin 7	nple	(Specify only highest gi	College (1-4or 5+)		kind of work done of OO NOT use retired		1	2	
2	filed w Hygier Sther th	S	17. Father's Name (First, Middle, Las	<i>t</i>)	con:	struction		Ker f e (First, Middle, Maid	en Sumame)	}
anc	e d stal	Be c	John	Harris		·	Sar		olcor	
Maryland	and Men Is marke	ဥ	19a. Informant's Name/Relationship		19b. Mailir		and Number or Run	al Route Number, Cit		
	1 and 2 Health a tem 27 is		Gloria L	farris_	297	22 SK:1	pton/co	rdova Rd	Cordo	Va MD, 21625 Town, State
ore e	of He	U 8	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	1	Ob. Place of Dispo cemetery, cren	sition (Name of natory or other place				
Ĕ	Pages tment of tent: If It		*4 □ Donation 5 □ Other (Spec	ify)	Bethel	Cemeter	ry 10/	21/04 Co	ambrid	ie, MD.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Importent: If Item 27 is marke any injury or other traumatic <u>once</u> .		21. Signature of Funeral Service Lice	C. Henr	4 5	In Wash	sington !	Hone, P. A.	ridge, N	10.21613
П			23a. Part1. Enter the disease, or conshock, wheart failure. List only	nplications that caused the or yone cause on each line.	death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest,	0,	Approximate Interval Between Onset and Death
	Physician	8 3	Immediate Cause (Final disease or condition resulting in death)	a Stre	re					
	/Medical Examiner		1	Due to (or as a cor	nsequence of):					
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	nsequence of):					
	cuted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.						
760,	eath certificate be executed attending physician and for use as the burial-transit	i Ex	resulting in death) Last	Due to (or as a cor	nsequence of):]	
∞	cate b	dicai	•	d						
9 X	certific iding p	by Physician/Med	IF FEMALE:	23c. If yes, outcome of pr	regnancy				23d. Date of del	ivery
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□ 4□Pregnant at time]Ectopic pregnancy] Other (specify)			Month	Day Year
<u>о</u>	t the c by the tacher	hys	9 ☐ Unknown	9□ Unknown						
Ś	quires that the death cer n signed by the attendin uld be detached for use		Part II. Other significant conditions	contributing to death but no	t resulting in the u	nderlying cause give	en in Part I.	23e. Did tobacc		o the cause of death?
Vital Record	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as t	Completed						24a. Was an autopsy performed	prior to death?	utopsy findings available completion of cause of 2 No
ta		a	25. Was case referred to medical				26. Place of Deal	h (Check only one)	12,700	22.10
	Physicien: r this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 PEVOutpatier		4 Nulsing In	ome 5 Residence		cify)
u o	ding Phy h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	ar) 28b. Time o Injury	Worl		28d. Describe how in	ijury occurred	
<u>sio</u>	Attending r death. sctor: After by the fune	Icati	2 Accident investigate 3 Suicide 6 Could not	be One Blace of Injury	At home farm str		Yes 2 □No	28f. Location (Street	and Number or Ri	ural Route Number,
Division of	Hospitel or Ai	Certification:	4 Homicide determine	building, etc. (S	pecify)	***		City or Town, St	ate)	
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai		Physician: To the best of my aminer: On the basis of exa and manner stated.				red at the time, date	and place, and due	to the cause(s)
	To the To the Comple	Ž	29b. Signature and title of certifier	4 111	ounter	29c. Licens	e number 60292		Date signed (Mont	n, Day, Year)
			30. Na te and address of person wh	o completed cause of death	(Item 23a) (Type,		T	1010110	por W	_ \
			31. Date filed (Month, Day Year)	32. Registrar's	Signature	191	Jan	MANIA	ICU MY	,
	St Regist	ate rar	OCT 2	0 2004	a B.	Good .				

	State of Maryland / Department of Health and Mental Hy 1 - State Registrar Certificate of Death	giene 004 34971
Physician	1. Decedent's Name (First, Middle, Last) CATHERINE BOSE HIGHEY 2. Date of De Month	
/Medical Examiner	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	4c. County of Death
Funeral	5. Social Security Number 6. Sex 7. And (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 2 Date of Birthday	y Year Country
Director	Usual Residence of Decedent	
with the Maryland a or 28a-f show Libe netified at Director		10d. Inside City Limits 1 ☐ Yes 2X No
19/16 Colors of the Maryle of the Maryle of the Maryle of thems 23s or 28s -f show that the Maryle of thems 23s or 28s -f show that the marified at the marified at the maryle of the Ma		10g. Citizen of What Country? USA
S6 Signature of the state of th	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
Haght Care 1215-0036 within 72 hours after one than "naturel; or ite while Exerciting and leaves of the property of the proper	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	Specify: White
Hud/ 121275-01 8d within 72 ho 9giene, "naturi 1. It is Mulical II.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16b. Kind of Business/Industry
- 4 B B B B		Hospital Maiden Sumanne)
	Herbert Clark Mary Evans	
Therine Tore, Maryla ges 1 and 2 should at of Health and Men If item 27 is marke or other traumatic	19a. Informant's Name/Relationship (Type, Print) Nathaniel Hughey, Sr. / husband 1201 Revolution Street, Har	
imore, Pages 1 &	20a. Method of Disposition 1 □ Burial 2 MCremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town, State
Eatimore, M. Baltimore, M. Pernit. Pages 1 and 2. Department of Health any portant: If tiem 27 is any injury or other transpace.	21. Signature of Funeral Service Licensee R.A. Ferris & Co., Inc. 10/20/04 22. Name and Address of Facility Lisa Scott Funeral Homo	West Chester, PA
О ш тогая	Lisa Scott Funeral Home, 552 Lewis Street, Havre 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ar	de Grace, MD 21078 rest, Approximate Interval Between
Physician /	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a	Interval Between Onset and Death
Examiner	Due to (or as a consequence of):	
executed in and ital-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undarrying Cause (Disease or injury that initiated events	
60, lbe exect to be exect to burial-tr		
C 6876(C 6876(C 6876(C 6876(C 7876	d. IF FEMALE:	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. The A hours after death. The Funeral Director. After this certificate has been signed by the attending physician and apletely filled in by the funeral director, page 2 should be detached for use as the burial-transited certification; To Be Completed by Physician/Medical Examin	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Xi No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year
Cords, P wrequires that been signed b should be deta	at it. Other significant containing to death out not resulting in the underlying cause given in Part 1.	obacco use contribute to the cause of death? es 2 □ No 3 □ Probably 4 □ Unknown
Division of Vital Records, or Attending Physician: The law requires ta after death. In by the funeral director, page 2 should be contificated by the funeral director, page 2 should be certification; To Be Completed by	24a. Was a autopuperformula autopuperformula yes	sy prior to completion of cause of
of Vital hysician: T hysician: T director, pa	examiner?	
on of ding Physis. After this funeral di		ow injury occurred
Division c spital or Attending P ours after death. filled in by the tuners	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (S City or Town	treet and Number or Rural Route Number, n, State)
To the Hospital within 24 hours a volument if to the Funeral if completely filled		ause(s) and manner as stated. late and place, and due to the cause(s)
To the within To the company of the the company of the the company of the the company of the the the the the the the the the the	29b. Signature and title of certifier 29c. License number 27 29c. License number 27	29d. Date signed (Month, Day, Year)
)	30. Na n address of person who completed cause of death (Item 23a) (Type, Print) My McWy M 615 My Mar Mark 104	mel Ain Maziny
State Registrar DHMH 17 Rev 1/2001	OCT 2 1 2004 Reserve & Small	

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			For State Registrar		Stat	te of Ma	ıryland / [Departm <i>Certific</i>			nd Me		giene	004	34	972
	Physici	an	1. Decedent's Nam								2.	Date of De		Year	3. Time	e of Death
	/Medic	cal	LUCY 4a. Facility Name (I	HAMI		HAMO:	R	4b (city Town	or Location of		ct 25	5 2	2004 County of Dear	7:1	5am ^M
	Examin	ier	CIVISTA		•				A PL.		Doam			IARLES		
	Funeral Director		5. Social Security N	Number	6. Sex 1 ☐ M 2	7. Age	(In yrs. last bir		nder 1 Year	If Under 24	Min.	Date of Bir (Month, Da ARCH	th av. Year)	9. Bird	hplace (State	te or Foreign
			Usual Residence of	f Decedent							411	AICH	J / 1.	719 1	IAINE	
	death with the Maryland ms 23a or 28a-f show	, join	10a. State ΔRVI. ΔND	10b. County	RLES		10c. City, Town									City Limits es 2 ☐ No
	r 28a-	rect	ARYLAND 10e. Street and Nu		X1112		LA	PLATA 10f	Zip Code		-		10g. Citiz	en of What Co		
	23a or	alD	1 MAGNO	LIA D	RIVE									USA	,	
	or Ita	by Funeral	11. Marital Status 1 Never Marr.		ed 1 🗍	Decedent E ed Forces? Yes 2 ZN es, Give		If Yes,	specify Cub specify No	Hispanic Origin an, Mexican, I Specify:	n? (Specify Puerto Ric	y Yes or No an, etc.)		4. Race - Ame Black, White Specify:	e, etc.	
-0036			3 XWidowed	15. Decedent	's Education	r or Dates:	16a.	Decedent's l	Jsual Occur	pation				d of Business/	WHITI	브;
215		Completed	(Speci	cify only highes andary (0-12)	-	eted) ege (1-4or 5-		(Give kind or life. DO NO	work done T use retire	during most o d)	of working		100.11	a or basiness	industry	
22		Con	9 17. Father's Name		(agt)	•		HOME	MAKE					N SEL	F	
A Jand	0 to 0	To Be	RALPH H							18. Mother's		irst, Middle, E. RY		iumame)		
ā	s 1 and 2 should be f f Health and Mental I itam 27 Is markad of othar traumatic eva	F	19a. Informant's Na			t)	19b.	Mailing Add	ess (Street	and Number				Town, State, 2	(ip Code)	
Σ	and 2 ealth a m 27 Is		PAT HAL		JGHTER		4.	.3 LI	NDEN	LANE,					646	
700	Pages 1 nent of H int: If itan			XCremation		from State		v, crematory	or other pla	·	Date			ation - City or		
LUC.	permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or othar tra once.		`4 ☐ Donation 21. Signature of Fu				ROPOLI	2 Name	and Addre	IATORY Ses of Facility FUNE					RIA,	VA
	HD 2 6 0		23a. Part1. Enter the shock, or hea	he disease, or	complications	that caused	the death. Do n	LA of enter the	PLAT	A, MA	RYLA	ND	2064	6	Approxim	nata
	Pnysician		Immediate Cause ((Final	only one cause	on each line			· (lu	rg, such as ca	irdiac or re	spiratory ar	rest,		Interval B Onset an	Between
	/Medical		disease or condition resulting in death)	n y	aDu	ue to (or as a	consequent		- (14)	, –					Wy K	wou
	Examiner	_	Sequentially list con	nditions,	b	49	515							1	4KK	KOLW
VI	nsit	Examiner	Sequentially list confiancy, loading to in cause. Enter Under Cause (Disease or	injury	RA	(+7-)	- VAQ L		Fis	trac					1 . 1/1/2	XOUN WYW
50,7	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) l	Last	c. Du	ue to (or as a	consequence								y ve k	norm
87	icate t physik s the b	dical			d											
Вох 6	requires that the death certific een signed by the attending p nould be detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent	t pregnant		s, outcome o	of pregnancy	ه حاد					23	d. Date of deli	very	
B	the atte	sicla	in the past 12 1 Pyes 2 9 Unknown	No	4□8	Pregnant at t Unknown		5 Other	pregnancy (specify)	/				Month	Day	Year
P.0	res that the de signed by the s be detached t		Part II. Other signif		ns contributino	to death bu	t not resulting in	the underlyin	n cause niv	en in Part I		23a Did to	abacco use	contribute to	the cause of	f death?
rds,	uires n sign	ed by		NBA	uced	A	GE.		g g				′es 2 🗆		•	Unknown
000	w d s	plete	1	Faclu	e t	0 7	Thru	2_				24a. Was		24b. Were aut	opsy finding	s available
<u> </u>	The ate h page	Completed									_	autop perfor 1 Yes	med? 2X No	death?	ompletion of 2□ No	cause or
- Vita	Physician: this certific ral director.	Be	25. Was case reference examiner?		, Hospital:	.			DOA Oth	26. Place of	-					
of	g Phy er this eral di	n: To	1 ☐ Yes 2 X	h		1 Inpatien Date of Injury (Month, Day	28b. Ti	me of	28c. Injur Wor	4 INUISII	-	5 Resid		Other (Spec	ify)	
jo jo	Attanding r death. actor: After by the fune	atlo	1 Natural 2 ☐ Accident	5 Pending investig	ation	(мони, рау	rear) in	jury M		k? Yes 2⊟No						
É	tal or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 🗌 Could n determin	ned 200. I	Place of Injur building, etc.	y - At home, fan (Specify)	n, street, fac	ory, office		28f.	Location (S City or Tow	Street and f m, State)	Number or Rui	al Route Nu	mber,
	Hospi 4 hou Funer tely fill	edical	29a. Certifier (Check only one)	Certifying	ABITIMET: On	o the best of the basis of e manner state	my knowledge, examination and ed.	death occurr or investigat	ed at the tin	ne, date and p pinion, death o	place, and occurred a	due to the o	cause(s) ar	nd manner as ace, and due	stated. to the cause	(s)
	To tha within 2 To tha complei	Σ	29b. Signature and	title of certifier	1 XTZ		٨ ~		29c. Licens	-		2	29d. Date s	signed (Month	Day, Year)	
				Lenel	y Ul	mes			n-00;	26262			17	152	100	1
	5			J. KL	E-IMAN	MD 1	ath (Item 23a) (1 $1711 \mathrm{L}$.	ype, Print) IVING	STON	RD FT	WAS	SHING	TON	MD 20	744	
	Sta		31. Date filed (Mont	h, Day, Year)	200#	32. Registrar	's Signature								1	
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DITIO		-					-	//		200						

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 1 34973 For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** 9:40 PM HAMMOND DETOBER 2004 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and numb Pleasant View Wising 4101 Old National 4b. City, Town, or Location of Death **Examiner** mount Airy, Mice Pike Carrol Mary land 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1 ☐ M 2 🖾 F 72 Feb_16, 1932 Director 214-30-1781 Maryland Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits in and Mental hygiene.
7 is marked other than "natural", or Itama 23a or 28a-1 show traumatic event, the Medical Examinar must be notified at 1 Yes 2K No Maryland Frederick Thurmont Direct 10e, Street and Number 10f Zin Code 10g. Citizen of What Country? 7174 Prospect Dr. 21788 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Bell Atlantic Telephone Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George C. Hammond irene Devilbiss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health ar Important: If item 27 is any injury or other trausonce. Warren Burger (son) 465 Morgan Station Rd. Woodbine, MD 21797 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location · City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Unionville, MD Linganore Cemetery 10/28/2004 21. Signature of Funeral Services 22. Name and Address of Facility Burrier-Queen Funeral Home and Crematory P. 1212 West old Liberty Rd. Winfield, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury ue to (or as a consequence of): Examiner I Records, P.O. Box 68760, S. The law requires that the death certificate be executed. physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year ū in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by mannoa 4 Onknown Ċ 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 4 Viursing Home 5 ☐ Residence 6 Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) of person who completed cause of death (Irem 23a) (Type, Print) Road old Kordm MI) CHURAN annapolis 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Howard Marv 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HILLEGAN umberl SACred MEART SDITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb 15, 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Communication) Days Hours ″fg10 1 ☐ M 2 🖾 F 214-07-1437 94 Usual Residence of Decedent 10a. State MD 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1x Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 21502 14510 N. Bel Air Dr. SW USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) laborer textile 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mae Dohrman Long Jacob Long 19b Mailing Address (*Street and Number or Rural Rou*te Number, City or Town, State Zio P.O. Box 252 Fort Ashby WV 19a. Informant's Name/Relationship (Type, Print) Frances Alkire 'niece 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Sunset Memorial Park 10/30/2004 Cumberland Burial 2 □ Cremation 3 □ Removal from State MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Nan 9 carbettis Fundiral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Coronan Due to (or as a considuence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical **Examiner**

burial-transit

physician is the burial

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 le marked oth any injury or other treumatic event QDGs.

Physician

/Medical

Examiner

Funeral

Director

r then "naturel", or Items 23a or 28e-f show Its Medical Examinar roust be notified at

Direct

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

Jer

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not re	sulting in the underlying cause given in Part I	. 23e. Did tobacc	to use contribute to the cause of death?
			24a. Was an autopsy performed	
25. Was case referred to medical		26. Place	of Death (Check only one)	
examiner?	Hospital: 1 ☐ Inpatient	R/Outpatient 3 DOA Other: 4 Nu	rsing Home 5 🗆 Residence	6 □Other (Specify)
27. Manner of Death → Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date of Injury (Month, Day Year) on	28b. Time of lnjury at Work? M 1 Yes 2	28d. Describe how in	njury occurred
3 Suicide 6 Could not 4 Homicide determine		nome, farm, street, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying I	Physician: To the best of my kn	owledge, death occurred at the time, date an ation and/or investigation, in my opinion, dea	d place, and due to the cause	e(s) and manner as stated.

State Registrar

29b. Signature and title of certifie

31. Date filed (Month, Day

DR. Sovil Gupta

625 Kent Avenue Cumber land, Md 32. Registrar's Signature 4 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

00033280

29d. Date signed (Month, Day, Year)

after death

within 24 hours a To the Funerel C

			1 - State of Maryland / Department of Health and Certificate of Death	Mental Hy	ygiene 200	4 34975			
\$	Physici /Medio	al	1. Decedent's Name (First, Middle, Last) Mary E. Hemler	2. Date of D Month OCt.	24, 200	4 9:05 A ^M			
	Examir Funeral	er	4e. Fecility Name (If not institution, give street and number) Hidden Treasures Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Westminster 7. Age (In yrs. last birthday) Months Days Hours Mir	S. 8. Date of B	lev. Yeer)				
	Director	i	168-14-1966	9-4-1	1916 Pe	nnsylvania			
	death with the Maryland ms 23s or 28s-f show trivial be notified at	Director	MD Baltimore Baltimore City			10d. Inside City Limits 1X Yes 2 □ No			
	ath with t	ral Dir	10e. Street and Number 10f. Zip Code 21214		United	•			
0000	hours after death w tural, or itema 23a	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 4 □ Divorced 1 □ Ves Q No Specify: 1 □ Yes Q No Specify:	Specify Yes or N into Rican, etc.)	Sanaitu	nerican Indian, nite, etc. nite			
0-0171	27 a si	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. Decedent's Usual Occupation (Give kind of work done during most of we life. DO NOT use retired) Homemaker	orking	16b. Kind of Busines	ss/Industry			
and 2		Be	17. Father's Name (First, Middle, Last) 18. Mother's Na	ame (First, Middle	Domest a. Maiden Sumame) Nary	ilc			
Mary	s 1 and 2 should by I Health and Menta item 27 is marked other traumatic ev	To	19a. Informant's Name/Relationship (Type, Print) Paul Hemler, Son 19b. Mailing Address (Street and Number or F	Rural Route Numb	ber, City or Town, State	Zip Code)			
more,	00		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date -27-04	20c. Location - City of	,			
pairimoi	permit. Page Department Important; If any injury or once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury	J.L. D Ave.,	avis Fune	eral Home			
0,0070	Physician and Springles of the private personnel of the personnel of the private personnel of the private personnel of the person	al Examiner	23a. Paff Infer the glaease, or complications that caused the death. Do not enter the mode of dying, such as cardial shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):			Approximate Interval Between Object and Death // Own 88/W			
O. BOX 661	sath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		23d. Date of de Month	elivery Day Year			
ords, r.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	- IIIi.	tobacco use contribute	to the cause of death? Probably 4 □Unknown			
ביים ביים	: The law re cate has be , page 2 sh	Completed		24a. Was auto perfo 1 Yes	psy prior to ormed? death?	autopsy findings available completion of cause of s 2 No			
2000	To the Hospital or Attending Physicien: The law within 24 buous spite death, within 24 buous spite death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	25. Was case referred to medical examiner? 1 Yes 2 No							
2	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo								
	the Hosp hin 24 hou the Funa uplately fi	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place (Check only one)	e, and due to the urred at the time,	date and place, and du	e to the cause(s)			
•	Twit		29b. Signature and title of certifier 29c. License number D25443		29d. Date signed (Mon	Joby, Year) 2004			
	6		30. Name and Address of person who completed cause of death (Item 23a) (Type, Print) Dr. John W. Middleton, 688C Poole Rd., Westm	inster	, MD 2115	7			
	Sta Registra		31. Date filed (Month, Day, Year) NOV 0 4 2004 32. Registrar's Signature						

State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Joseph Thomas Jennings October 25, 2004 5:30 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Nursing Center Leonardtown St. Mary's If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 578-36-6088 June 21, 1930 Washington, D.C Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evander must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No Funeral Director St. Mary's Lexington Park MD 10e. Street and Number 10g. Citizen of What Country? 19479 N. Snow Hill Manor Rd. 20653 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify δ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 5+ Mechanical Engineer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Frank Jennings Catherine Hans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20653 19a. Informant's Name/Relationship (Type, Print) Mary Anne Jennings (WIFE) 19479 N. Snow Hill Manor Rd. Lexington Park, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) St. James Cemetery Oct.29,2004 Lexington Park, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee David A. Goff MO1095 22955 Hollywood Rd. Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of) Examiner YEARS CORENALY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be executed Due to (or as a consequence of) Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) P.0. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death Division of Vital Records, by TYPE 1 DEARETES WELLTUS 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed ALMEINERS DEWENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 Yes 2 No 1 🗆 Yes Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certification: 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide To the Hospital of within 24 hours of To the Funaral D 1 Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D56091 October 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rajbinder S. Gill, M.D. 24035 Three Notch Rd. Hollywood, Maryland 20636 31. Date filed (Month, Day, Year) OCT 27 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Johnson 10:08 James Richard October 14 2004 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Grow Hospital MALCOLA vince t Under 24-trs. 8. Date of Birth Hours Min. 0 9 - 2 0 - 1 9 4 7 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Days 1€M 2□F 57 Yrs. Tennéssee 411-76-0940 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Accokeek MD Prince Georges 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20607 USA 15509 Livingston Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired)
Police Chief Naval District Of Elementary/Secondary (0-12) College (1-4or 5+) Washington 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Geraldine Richard Johnson James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 15509 Livingston Rd. Accokeek, MD 20607 Valerie Johnson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-22-2004 Riverdale, MD Riverdale Park * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Taylor's Funeral Home 21. Signature of Funeral Service Licensee 1722 North Capitol St. NW Wash. DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on requise on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arterioscherotic Heart Disease Hyperteroloe disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 FR/Outpatient 3 □ DOA 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 140055927 ddress of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital o within 24 hours aft To the Funeral Di

State Registrar

DHMH 17 Rev 1/2001

Physician

/Medical

Examiner

Funeral

Director

or 28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Electrical 2006s.

Physician

/Medical

Examiner

attending physician and for use as the burial-transit

or Attending Physician: The law requires that the death certificate be executed

certificate has

s after dec.

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Division of Vital Records, P.O. Box 68760.

Baltimore, Maryland 21215-0036

Examiner must be notified at

Director

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Completed

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Completed

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Medical Certification: To



ORIGINAL

		State KBH Registrar			Certific	ent of Health and ate of Death	Re	2. U U 4	3497
Physicia	_	Decedent's Name (First, Middle	le, Last)				Date of Death Month	Day Year	
/Medica	al -	4a. Facility Name (If not institution	JONES		a Allen .		AUGUST	19,2004	
Examine	er	Saint Joseph				ity, Town, or Location of De Tows		4c. County of De	timore
Funeral Director		5. Social Security Number	6. Sex 1 M 2 ☐ F	. Age (In yrs. las	t birthday) If Un Mont	hs Days Hours M	n. (Month, Day,	Year) 9. B 9, 200 4	irthplace (State or Fore Country) MARY / Ar
Hygiene. ther than "natural", or itams 23a or 28a-f show ant, it at Medicul Examinet must be inclined at	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City,	Town or Location				10d. Inside City Lim
ida nyglene. id other than "natural", or itams 23a or 28a-1 show evant, ita Medicul Eras it att mast be rediffed at	Director	MARYLAND ANNE	ARUNGE	1 PA	ASADEN				1 ☐ Yes 2
st ke n		10e. Street and Number 226 BAR HAR	has Pos	4	101.	Zip Code	10	g. Citizen of What C U, S , A	
SE Draw	Funeral	11. Marital Status		lent Ever in U.S.	13. Was De	ecedent of Hispanic Origin? specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Am Black, Wh	rerican Indian,
Examples	þ	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried 1 ☐ Yes 2	No		s 2 No Specify:		Specify:	1 1
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othar traumatic ev		19a. Informant's Name/Relations				ess (Street and Number or	Rural Route Number,	City or Town, State,	Zip Code)
othar to	-	PATRICK & COLLEGE 20a. Method of Disposition	N JONES (PA		ZZ6 B	AR HARbOR I		Oc. Location - City o	
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any injury conce.	Ī	21. Signature of Funeral Service		Viciy	REJEEME 22. Name	and Address of Facility	Lajor D	41 to. C.ty,	MARYIANO
any ir		James W. E	agan Jr.,	M.D.	51.505	eph Med. CEN.	7601 Osla	FR DA.	21264
п		23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cau t only one cause on eac	used the death. ch line.	Do not enter the n	node of dying, such as cardi	ac or respiratory arre	st,	Approximate Interval Between Onset and Death
ian ical	İ	Immediate Cause (Final disease or condition resulting in death)	-			Y 22-23 WE	EKS		55 MIN.
ner			Due to (of	r as a consequer	ice or):				
	3								
	ine	Sequentially list conditions, if the season to immediate cause. Enter Underlying	Due to (or	r as a consequer	nce of):				
_ լ։	хаш	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	r as a consequer					
E L	Exam	that initiated events	c	2010-1-011					
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	-	For State Registrar		aryland / Dep ————————————————————————————————————	rtificate of l	Death	R	leg. No.	34979
nysicia Medica	n	1. Decedent's Name (First, Middle, Sister Helen N				las .	2. Date of Dea Month Oct. 2	Day Year 8 , 2004	8:50 A. M
xamine neral ector		012-14-6949	are Center	e (In yrs. last birthday 86 Yrs.	Emmits		8. Date of Birth (Month, Day) Sept. 1	4c. County of Death Frederi (, Year) 9. Birth; County 19. Birth; C	ck place (State or Foreign ntry)
3		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
rotifie	Director	MD Frede	erick	Emmits	burg 10f. Zip Code		1	Iog. Citizen of What Cou	1 ☑ Yes 2 ☐ No ntry?
ust be		335 S. Seton A			21727			U.S.A.	
Nation I	by Funeral	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ▼ N If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		
event, the Medical Exactinet must be notified at	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 grades	Education grade completed) College (1-4or 5	+) (Give	edent's Usual Occupa skind of work done of DO NOT use retired eligious	ation furing most of worki)	ing	16b. Kind of Business/In Georgetown \text{\text{Monastery}}	dustry
matic event,	e Re	17. Father's Name (First, Middle, La Martin Joyce	sst)		JII BIOGO	18. Mother's Name	(First, Middle, I		
umatio	2 │	19a. Informant's Name/Relationship	(Type, Print)	19b. Mail	ng Address (Street a			r, City or Town, State, Zip	Code)
y or other treumatic	-	Sister Camilla 20a. Method of Disposition 1 \(\text{Derival} \) Burial 2 \(\text{Cremation} \) Cremation 3	☐Removal from State	20b. Place of Disp cemetery, cre	S. Seton	9)	Date	20c. Location - City or To	own, State
any injury or o		*4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lic		CONVENT 2	WN VISITA: 2. Name and Addres 210 W. MAT	s of Facility SKI	LES FUN	WASHINGTON, ERAL HOME EG, MD. 2172	
	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause that initiated events resulting in death) Last	. altre	a consequence of): a consequence of): a consequence of):	do F tic v	usuffi	cience la d	island	Cys 20 year
for use	Pnysician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)			23d. Date of delive Month	ery Day Year
pe j	2	Part II. Other significant conditions	s contributing to death bu	it not resulting in the u	nderlying cause give	n in Part I.	23e. Did tob	pacco use contribute to the	ne cause of death? ably 4 □Unknown
r, page 2 sho	Сощрівтва						24a. Was ar autopsy perform 1 Yes 2	y prior to cor ned? death?	psy findings available mpletion of cause of
al direct	0	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	Hospital: 1 ☐ Inpatier 28a. Date of Injur (Month, Day)		f 28c. Injury Work	at 2	ne 5□ Reside	e ince 6 ⊡Other <i>(Specify</i> ow injury occurred)
led in by th	Ceruncation	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm, st . <i>(Specify)</i>	eet, factory, office	2	28f. Location (Str City or Town	reet and Number or Rura , State)	Route Number,
pletely fil.	Medical	29a. Certifier 1 ☐ Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner state	examination and/or in	h occurred at the time vestigation, in my op	e, date and place, a inion, death occurre	and due to the ca ed at the time, da	use(s) and manner as state and place, and due to	ated. the cause(s)
Coo		29b. Signature and title of certifier	lla	audl	29c. License	number 1876J		OCTOBER 28,	
State	9	31. Date filed (Month, Day, Year)	o completed cause of de COLL, M.D., 32. Registra	310 s. SE	Print) TON AVE.,	EMMITSBU			2004

State of Maryland / Department of Health and Mental Hygiepen () [4 34980 1- State Registrer/MEND#10b-f, 19bperINF10/22/04, BMW, MCertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 17, 2004 OCTOBER **Physician** MICHAEL KROFCHIK, SR. 10:50A. M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Renaissance Gardens @ Riderwood Village Silver Spring Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Day, Year) April 6, 1916 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1**⊠** M 2□ F 209-22-7923 Pennsylvania Director Usual Residence of Decedent the Maryland Greenbert 10d. Inside City Limits 10a. State Prince George's or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Director 10e. Street and Numbe 6 Fayette 3118 Gracefield Road, 20770 10g. Citizen of What Country? Place 10f. Zin Code #201 20904 United States 238 death 12. Was Decedent Ever in U.S. Armed Forces? 1∑ Yes 2 □ No tYes, Give year or Dates: 1946–1956 or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours after at Hygiene. other then "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Federal Government College (1-4or 5+) 2 Elementary/Secondary (0-12) United States Army Hospital Administrator injury or other treumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if Item 27 ie marked othe any injury or other treumatic event 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Krofchik Julia John Falatek 156. Making Address Street and William Provide Number City of Your, State, Zio Code 20904 19a. Informant's Name/Relationship (Type, Print) 3118 Cracefield Rd., #201 Silver Spring, Maryland Martha Krofchik -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cem. 11/2/2004 Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licen e 4400 Powder Mill Rd. Beltsville, Maryland 20705 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Cancer of rancreas, lungs and liver disease or condition resulting in death) 1month /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, beding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit and Due to (or as a consequence of): Box 68760 ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Hinknown Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Coronary artery disease 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Attending 5 Pending 1 Natural al or Attendin after death. I Director: Af investigation 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 18, 2004 D59524 Juhumana 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loveen Puthumana, M.D. 3110 Gracefield Rd. Silver Spring, Maryland 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 20 2004 Registrar

			1- State of Maryland / De Registrar	partment of Health and Me e <i>rtificate of Death</i>	ental Hygier Reg. 1										
			Decedent's Name (First, Middle, Last)	2	2. Date of Death	3. Time of Death									
	Physici /Medic		Elisa A. Kronz			18, 2004 7:15 a M									
Ì	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death											
			FutureCare Chesapeake	Arnold		Anne Arundel									
	Funeral		5. Social Security Number 6. Sex 1 M 2 TF 7. Age (In yrs. last birthd.	Months Days Hours Min.	3. Date of Birth (Month, Day, Yea										
	Director		073-62-5786		Jun. 14,	1963 NJ									
	yland		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits									
	e Mar	ctor	MD Anne Arundel	Annapolis		1 ☐ Yes 2 🔀 No									
	ith th	Director	10e. Street and Number	10f. Zip Code	10g. (Citizen of What Country?									
	ath w	rai	1547 Star Pine Drive	21401		USA									
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel", or Items 23a or 28a-f show eny injury or other treumetic event, The Medical Examinar must be notified at once.	by Funerai	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	 Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto Ri Yes 2 No Specify: 	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White									
5 0	72 ho	Completed	(Specify only highest grade completed) (G	cedent's Usual Occupation ve kind of work done during most of working	16b.	Kind of Business/Industry									
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7	iled v dygie ther ti	S	17. Father's Name (First, Middle, Last)	Programmer 18. Mother's Name (First Middle Maid	IMS									
and	d be f intal h	Be c	Peter Forgione	Patricia		en Sumanie)									
Maryland	shoulk nd Me mark metir	٦ ک		iling Address (Street and Number or Rural I		v or Town, State, Zip Code)									
S	nd 2			17 Star Pine Drive, 2											
Baltimore,	Pages 1 a nent of Hea snt: If item ury or othe		197 Burial 2 Cremation 3 Demoval from State cometery, o	position (Name of ematory or other place) Mem. Gardens	21, 2004 Da	Location - City or Town, State avidsonville, MD									
Balti	permit. Departr Importe eny inji		21. Signature of Fonsital Service Licenses	22. Name and Address of Facility Barranco & Sons, P. 1 495 RGov. Ritchie Hy	wy, sever	na Park Funeral Home na Park, MD 21146									
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approxim Interval B												
	Pnysician	8 1	Immediate Cause (Final disease or condition resulting in death)	Sclerosis		Onset and Death U.P.C.S									
	/Medical Examiner		Due to (or as a const uence of):												
	42	r e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):												
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	rtifica ng ph	Medi	IF FEMALE:												
.O. Box	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 morths?	B⊟Ectopic pregnancy i⊟ Other (specify)		23d. Date of delivery Month Day Year									
<u>a</u>	res that the de igned by the a be detached f		Part II. Otifer significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?									
S	uires sign Id be	d by	dusphagia		1 ☐ Yes	2 No 3 Probably 4 DUnknown									
Vital Records,	ne law requir has been si ge 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?									
<u>a</u>	i icien: The lav certificate has rector, page 2	e Co	25. Was case referred to medical	26. Place of Death (1 Yes 2	fo 1 ☐ Yes 2 ☐ No									
	/sicie s cert direct	0 8	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other		6 ☐Other (Specify)									
0	Attending Physicien: r death. sctor: After this certific by the funeral director,	n: T	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at 28c	d. Describe how inj										
Ö	andin ath. or: Aft	atio	2 Accident investigation	M 1 ☐ Yes 2 ☐ No											
Division of	l or Atten after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28s. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 286	f. Location (Street a City or Town, Sta	and Number or Rural Route Number, ite)									
Ω	urs af urs af urel D														
	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate hi completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and investigation, in my opinion, death occurred	d due to the cause(at the time, date a	s) and manner as stated. nd place, and due to the cause(s)									
\	To the within 2 To the complet	Σ	29b. Signature and title of certifier	10 29c. License number 050725	00	eate signed (Month, Day, Year)									
_		•		no Hwy Millers in	lle 1	10 21108									
	Sta Registr		31. Date filed (Month, Day, Year) 32. degistrar's Signature	bark	,										

			For State Registrar	State of Maryland /	Depa <i>Cer</i>	rtment of Heal	lth and M ath	ental Hyg	gien 2 0 0 4	34982		
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Dea Month	Day Yea	3. Time of Death		
	/Medic		William E. Kist 4a. Facility Name (If not institution, giv			4b. City, Town, or Loca	ation of Death	Oct.	15 200 4c. County of De			
	Examin	er	7101 Bay Front			Annapolis	ation of Death		Anne Ar			
	Funeral		5. Social Security Number 6. S		oirthday)	If Under 1 Year If U	Inder 24 Hrs.	8. Date of Birth		Birthplace (State or Foreign Country)		
Ь	Director		191-14-6386	≜ M 2□F 81	Yrs.	Months Days Ho	ours Min.	April 2	onth, Day, Year) Country Country Pennsylvania			
	, od		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	!	akia -						
	shov	7								10d. Inside City Limits 1. Yes 2 □ No		
	the N	Director	Maryland Anne Ar	undel Annap	0118	10f. Zip Code			10g. Citizen of What			
	with Sa or		7101 Bay Front D	rive #3304		21403			United Sta	,		
	death ms 2%	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. W	as Decedent of Hispan	ic Origin? (Spe	cify Yes or No-	14. Race - Ar	merican Indian,		
9	after or Ita	F	1 ■ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cuban, Me ☐ Yes 2 No Sp	ecify:	rican, etc.)	Black, W			
93	within 72 hours after death with the Maryland ene. than 'natural', or Itams 23e or 28e-f show ha Medical Exercit et roust be rediffed at	d by	3 Widowed 4 Divorced	Year or Dates:			oony.		Specify: W	nite		
7	"natu	Completed	15. Decedent's E (Specify only highest gra		(Give I	ent's Usual Occupation kind of work done during O NOT use retired)	most of workir	ng	16b. Kind of Busines	ss/Industry		
12	withir ene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		draiser				1		
g 5	filled Hygi sther		17. Father's Name (First, Middle, Last		Lun		Mother's Name	(First, Middle,	Maiden Sumame)	relations		
an	ld be lental ked ic av	To Be	C. Harold Kist	ler		F	Ruth He	lene Sm	ith			
Maryland 21215-0036	shou s mai		19a. Informant's Name/Relationship (Type, Print) 19	b. Mailing	Address (Street and N	lumber or Rura	Route Number	r, City or Town, State	, Zip Code)		
Σ	iges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23a or 28a-f show or other traumatic avent. If a Medical Eraci metricular be retified at		John D. Kistler/		22 T	enth Flace	Verc-Be	each F	L 32960			
ore	ges 1 of Ho If itar		20a. Method of Disposition 1 □ Burial 2 ■ Cremation 3 □	Removal from State cemet	ery, crem	ition (Name of atory or other place)	I L		20c. Location - City			
Baltimore,	. Pag tment tant:		' 4 ☐ Donation 5 ☐ Other (Special			e Crematory						
Bal	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or othar tra <u>once.</u>		21. Signature of Funeral Service Lice	Romandu	+	7 Duke of G				eral Home, Inc		
	cate be executed // Medical Examiner ithe burial-transit ithe burial-transit	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence condition of the conditio	ry f e of):			respiratory an	551,	Interval Between Onset and Death		
Box 68760,	eath certifi attending for use as	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d		Ectopic pregnancy Other (specify)			23d. Date of d	lelivery Day Year		
o.	0 0	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown								
rds, P	Se us	d by P	Part II. Other significant conditions	contributing to death but not resulting	in the un	derlying cause given in	Part I.			to the cause of death? Probably 4 — Unknown		
Records,	elaw hasb je 2 sl	ompieted						24a. Was a autops perform	med? prior to death			
Vital		e C	25. Was case referred to medical			26.	Place of Death	1 ☐ Yes :		es 2 No		
<u> </u>	ys dis	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/C	Outpatient	3 DOA Other: 4	☐ Nursing Hom	ne 5 Reside	ence 6 □Other (Sp	pecify)		
n of	ding Ph h. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. (Month, Day Year)	. Time of Injury	28c. Injury at Work?	2	8d. Describe ho	ow injury occurred			
Division	Attan er deat actor: by the	27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number or Rural Route Number of Street and Number of Street and Number or Rural Route Number of Street and N										
	To the Hospital or within 24 hours afte To tha Funaral Dis completely filled in	Medical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exam	nysician: To the best of my knowledgeniner: On the basis of examination a and manner stated.	ge, death and/or inve	occurred at the time, da	ite and place, a , death occurre	nd due to the ca	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
	To the within 2 To tha comple	Me	29b. Signature apolititle of certifier	1 1		29c. License num	ber	2	9d. Date signed (Mo	nth, Day, Year)		
			> pperh.	July -		1050	118		OCT 18	2004		
			30. Name and address of person who	completed cause of death (Item 23a)) (Туре, Р							
			John Jackson, MD	2003 Medical Pa	arkwa	y Annapol	is, MD	21401				
	Sta Registi	-	31. Date filed (Month, Day, Yéar) OCT 19	2004 32. Registrar's Signature	A	nede						

12/16/04 KBH g838 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend 23a per Dr.

State of Maryland / Department of Health and Mental Hygien 0 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lest) 2 Date of Deeth 3. Time of Death Year Physician sard. 10 Mar 10 04 atrice /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Neme (If not institution, give street and number) Examiner Oh everti 7. Age (In yrs. lest birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 - Q-Y Birthplace (State or Foreign Country) **Funeral** 4 6 Months Days 1 □ M Marylana Director 10 Usuel Residence of Decedent the Marylend 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: if from 27 is marked other than "naturel", or froms 23s or 28s-f show injury or other traumetic event, the Medical Examinat must be notified at 1₽ Yes 2□ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? USA Funeral 5825 2073. Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours efter 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Merried Baltimore. Maryland 21215-0020 1□Yes 2□No Specify: Black Specify: Black δ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 end 2 should be filled within Depertment of Health end Mentel Hygiene. Important: If Item 27 is marked other than ' Elementery/Secondary (0-12) College (1-4or 5+) nfant Infan 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Adrian ၉ Hmari. Lione 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard conce Barnes 20b. Place of Disposition (Name of Date 20a. Method of Disposition 2 Location - City or Town, crematory or other place 1 ☐ Burial 2 ☐ Cremation 3 Pemoval from State 4 ☐ Donation 5 ☐ Other (Specify) 1. Signature of Funeral Service Address of Fecility inf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Prematurity Examiner Due to (or as a consequence of): chomioamniotitis Examine ettending physician end I for use es the bunel-trensit The law requires thet the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be deteched 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ٥ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed has TLIVES ELINE 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Naturel 2 Accident 5 Pending 1 🗌 Yes investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature end tit 29c. License number 29d. Date signed (Month, Day, Year) eted cause of death (Item 23e) (Type, Print) 30. Name end address of 3001 Hos Norene Registra s Signeture 31. Date filed (Month, Day 28 State

DHMH 16 Rev 6/95

Registrar

Amend item #29c perMI) G837 11/3 04 TT
State of Maryland / Department of Health and Mental Hygiens

The Amend of 4c 10/22/04 LDB DOR Cartificate of Death 1- State Registrar Amended 4c, 10/22/04, LDB, DOR Certificate of Death 34984 Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Year benjamin Linthicam 2004 10:10 AM 0 S /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hayna enter DIVILLE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1 № M 2 🗆 F 83 Months Days Hours 219-10-65 Director 10/1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic avant, the Medical Exarcher must be notified at 1 ☐ Yes 2 📈 No Director MD Dorchester Church Creek 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 1820 Taylors Island Road 21622 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: 3 Widowed 4 Divorced WWII Year or Dates: natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 ! Hygiene. othar than "r Elementary/Secondary (0-12) College (1-4or 5+) 11 s 1 and 2 should be filed w Health and Mental Hygier tem 27 is marked othar th dredging operations manager state government 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Josiah Francis Linthicum Clara Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Virginia Linthicum P. O. Box 96, Church Creek, MD wife 21622 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State ŏ permit. Page Department Important: If any injury o * 4 ☐ Donation 5 ☐ Other (Specify) Old Trinity Churchyard 10/21/04 Church Creek, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Subdural nemationa disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760 CERTIFICATION APPROVED BY MEDICAL EXAMINER Physician/Medical use as tha mithall, Mi IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Dav Year 5 Other (specify) P.O. I 1 Yes 2 No detached 9 Unknown 9 🗌 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed certificate 2 No Division of Vital 1 Yes tha Hospital or Attanding Physician: director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ✓ Yes 2 ☐ No Hospital: 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 10/9/2004 death. investigation 1 ☐ Yes 2 ZNo 2 Accident Fal unk Diractor: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide hours after filled in home 1820 within 24 hours a Taylors Island 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P19028 10/18/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene Baltimore Auerbach MD MO 31. Date filed (Month OCT 2004 32. Redistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Pa 2 0

State of Maryland / Department of Health and Mental Hygien 34985 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Day Yeer VIOLET BLANCHE LEAGUE OCTOBER 19, 2004 12:45 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING FACILITY CENTREVILLE QUEEN ANNE'S If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 👿 F 78 Director 219-16-7866 DEC. 8, 1925 MARYLAND Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD ANNE ARUNDEL GLEN BURNIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Itema 23a 7744 WEST DRIVE 21060 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE þ Specify: 3 ☐ Widowed 4 MDivorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 FACTORY WORKER INDUSTRIAL filed of Health and Mental Hygi Itam 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be CHARLES V. SPARENBURG 2 HAZEL GILLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BARBARA DUFF/DAUGHTER 332 OLD LINE DRIVE, CENTREVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Importent: If Ita 1 🕱 Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) MEADOWRIDGE CEMETERY 10/22/2004 BALTIMORE, MD 21. Signature of Funeral-Service Licenses once. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MD 21619 23a. Part1. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Rechal Physician Concinomo disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner frank leading to inmedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and I-transit death certificate be executed physician ar Due to (or as a consequence of): Physician/Medical as esn IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Year Day 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy page certificate 2 \$ 1 ☐ Yes Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: Certification; To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA ♦ Amursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 1 Accident 5 Pendina within 24 hours after death.

To the Funeral Director: A investigation 1 Tes 2 🗆 No the 1 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) To the 29b. Signature and title of certified 29c. License number 32036 do (Jw

State Registrar

10/21/04

DHMH 17 Rev 1/200

Maryland 21215-0036

Baltimore,

P.0.

Division of Vital Records,

シロト

30. Name and

31. Date filed (Month, Day, Year) 32. Registrar's Signature

ORIGINAL

dress of perso who completed cause of death (Item 23a) (Type, Print)

The state of the state of

			1 - For State Registrar			of Maryla	and / Depa	artment of rtificate of	Health and <i>Death</i>		Reg. No		3498	16
I	Physici		1. Decedent's Nam			cence				2. Date of D Month 10	eath Da 19		3. Time of D	
7	/Medic Examin		4a. Facility Name (4b. City, Town,	or Location of Dea			County of [I
		gra T	Casey H			,			r Spring			Montg		
L	Funeral Director		5. Social Security N 052-16-9 Usual Residence o	9303	Sex 1☐M 2፟XF	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days		n. (Month, D	pay, Year)	9. B:	Birthplace (State or Country) rooklyn, N	Foreign VY •
	yland 10w		10a. State	10b. County		10c.	City, Town or Lo	cation					10d. Inside City	Limits
	Ba-fsh	ctor	MD	Montgome	ery		Silver	Spring					MT Yes 2	2 🗌 No
	with th	Director	10e. Street and Nu		_	# = = =		10f. Zip Code				tizen of Wha	t Country?	
	ns 23	Funeral	3/01 Int	ternation		#238 cedent Ever in	U.S. 13.	20906 Was Decedent of		Specify Yes or N	US		American Indian,	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Marical Examinar must be multibut at once.	by		ried 2⊠ Married 4 □ Divorced	Armed F	orces? 2 📉 No ive		If Yes, specify Cut 1 ☐ Yes 2 ☑ No	Hispanic Origin? (pan, Mexican, Pue Specify:	irto Rican, etc.)			Vhite, etc.	
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ylar	Menta Menta arked artic ev	To B	Samue1	C. Hudne	11, Sr.				Fannie	e Brown				
Mar	12 sho		19a. Informant's N	ame/Relationship	(Type, Print)				t and Number or F					
ē,	Healt Healt tem 2		Tony Law 20a. Method of Dis	rence/So	nn	201		LIVERSEO: esition (Name of matory or other pla	ne Ct. S:	Date Date			or Town, State	
Baltimore,	Pages ient of nt: If i			☐ Cremation 3 5 ☐ Other (Spec		Jiale		natory or other pla n Cemete:	1	26-04		klyn.		
alti	armit. epartrr iporta iy inju		21. Signature of Fu	uneral Service Lice	ensee				ess of Facility M					
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	Physician		snock, or nea Immediate Cause disease or condition	ne disease, or con art failure. List only (Final on	y one cause on	caused the de each line. illity	eath. Do not ent	er the mode of dy	ng, such as cardia	ac or respiratory a	arrest,		Approximate Interval Betwee Onset and De	
×	/Medical Examiner		resulting in death)	((or as a cons								
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	nd nd transit	Examiner	cause. Enter Under that initiated events	artying injury		ikocyto								
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	The law requires that the death cert atte has been signed by the attending bage 2 should be detached for use a	by Physician/M	IF FEMALE: 23b. Was deceden in the past 12 1 □ Yes 2 □ 9 □ Unknown	months?	1□Live	utcome of predibirth 2 Fe nant at time on nown	etal death 3	Ectopic pregnanc Other (specify)	у			23d. Date of Month	delivery Day Ye	ar
ds, P.	uires that i signed by Id be deta	d by Ph	Part II. Other signit	ficant conditions	contributing to	death but not r	esulting in the u	nderlying cause gi	ven in Part I.		tobacco L		e to the cause of dea	
Records,	law require as been si 2 should t	olete								24a. Was	s an	24b. Were	autopsy findings av	ailable
tal Re		Be Completed	25. Was case refer	red to medical					26 Place of De	auto perfect 1 Tyes	ormed? 2 No	death	to completion of cau i? 'es 2 \sum No	se of
Ĭ.	Physician: rthis certifica ral director,	ToB	examiner? 1 🗌 Yes 2🙀	No	Hospital: 1	Inpatient 2	☐ EFVOutpatien	t 3 DOA Ott	200			6XIOther (S	pecify)HOspic	e
Division of Vital	Attending Pt ir death. ector: After th by the funeral		27. Manner of Deat 1 X Natural 2 ☐ Accident	5 Pending investigation	on	of Injury oth, Day Year)	28b. Time of Injury	Wo	ry at rk? ∣Yes 2 □ No	28d. Describe	how injur	y occurred		
DIX	tal or Att rs after de al Directo ed in by t	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not I	286. Plac	e of Injury - At ling, etc. <i>(Sp</i> e	home, farm, str cify)	eet, factory, office		28f. Location (City or To			Rural Route Numbe	ır.
	To the Hospital or Attanding Physician: within 24 hours after deals, To the Funeral Director: After this certific completely filled in by the funeral director,	edical	29a. Certifier (Check only one)	2 Medical Exa	miner: On the	e best of my k pasis of exami nner stated.	nowledge, death nation and/or inv	occurred at the ti restigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner I place, and o	as stated. due to the cause(s)	
	To the within To the comple	Σ	29b. Signature and	title of certifier	1 -		Mn	29c. Licens			29d. Dat	e signed (Me	onth, Day, Year)	
Λ	(0)		30. Name and addr	~ / *	completed at			D356	35		Octol	ber 20	, 2004	
K	(20)			ess o y person wng Kaplan, M					ilver Spi	rino. Ma	200	906		
H	Sta Registr		31. Date filed (Mon	th, Day, Year) 2 1 200	2.	Registrar's Sig								

Loleta Lawsaug - 2013/1928

Please Type or Print in Black Indelible Ink.	Ensure All Copies Are Legible.
State of Maryland / Department of H	ealth and Mental Hygiene 0 0 1

		1 - State Registrar	State of Maryland /	Certificate	of Death	F	Reg. No.	34987
Physic	ian	1. Decedent's Name (First, Middle, La				2. Date of Dea Month	Day Year	3. Time of Death
/Medi		Emma Loleta Will 4a. Fecility Name (If not institution, giv		4h Cihi I	Town, or Location of Dea		18, 2004	5:00 PM
Exami	ner	Laurel Regional	· ·			щи	4c. County of De	
Funeral		5. Social Security Number 6. S			1 Year If Under 24 Hr	s. 8. Date of Birth	Prince 9.B	George 's irthplece (State or Foreign
Director		225-14-8312 Usual Residence of Decedent	□м 2Ы 84	Yrs. Months	Days Hours Mir	oct. 3	, 1920 v	irthplece (State or Foreign Country) Lrginia
aryland show	_	10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
the Ma	Funeral Director	Maryland Prince	George's Ade:	lphi 10f. Zip	Code		10g. Citizen of What C	1 Yes 2 No
3a or	<u></u>		1 D 3 m01				•	Southtry?
death ms 2	Jera	3210 Powder Mil	12. Was Decedent Ever in U.S.		783 ent of Hispanic Origin? (ify Cuban, Mexican, Pue	Specify Yes or No-	USA 14. Race - Am	perican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show many larger or the Medical Examination and the Inviting of the traumatic event, the Medical Examination until be Inviting at an Annae.	þ	1 ☐ Never Married 2 ☐ Married 3X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		ify Cuban, Mexican, Pue	rto Rican, etc.)	Black, Wh	ite, etc.
72 ho	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16	a. Decedent's Usual	l Occupation k done during most of w	diag	16b. Kind of Busines	s/Industry
ithin Be.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use	e retired)	orking		
led w lygier her th		12		Homemak			Own Ho	ome
be fill	Be	17. Father's Name (First, Middle, Last)	7.7 1 2 2 1			me (First, Middle,	,	
d Mer narke	2	Richard Mullins				Ola Howry		
d 2 sl th an 7 ls r traur		19a. Informant's Name/Relationship (Thomas A. Lawrence			(Street and Number or F			
1 an Heal Heal Sem 2		20a. Method of Disposition	20b. Place	of Disposition (Nam-	stone Drive		Spring, MI 20c. Location - City o	
ment of tent: If if jury or o		1 St Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify	Gat	ery,crematory`or ot te of Heav Cemetery	ven	ober 22,	Silver Spri	ing, Maryland
Departing Departing Important Import		21. Signature of Funeral Service Licen	2	Francis 500 Uni	Address of Facility J. Collins versity Bly	Funeral	Home Inc. ilver Spri	ng, MD 2090]
		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the death. Do					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	a Aspiration Pne					Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequence					
xaiiiiici	L	Sequentially list conditions, if any, leading to immediate	b. Respiratory Fa					
bed Isit	ule le	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	∋ or):				
al-trai	Examiner	that initiated events resulting in death) Last	c. Hypoxia Due to (or as a consequence	e of):				
icate be executed physician and s the burial-transit		l	d					
titicat ng phy as the	Medical		<u> </u>					
attendin tor use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	h 3 Dectania ara	ananau.		23d. Date of de	livery
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and telly filled in by the funeral director, page 2 should be detached tor use as the burial-transit	Physician/I	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of death 9☐ Unknown	th 3 LEctopic pre- 5 Cher (spe-			Month	Day Year
res that the de igned by the a be detached to		Part II. Dther significant conditions of	ontributing to death but not resulting	in the underlying car	use given in Part I.	23e. Did tob	pacco use contribute to	o the cause of death?
quires in sign uld be	ed by					1 □ Ye	es 2 No 3 P	robably 4 XUnknown
s been si	Completed					24a. Was ar	n 24b. Were a	utopsy findings available
The lay te has age 2	mo					autops	y prior to death?	completion of cause of
yslcian: The is certiticate hidirector, page	a	25. Was case referred to medical			26. Place of De	1 ☐ Yes 2 ath (Check only one		s 2 No
lystci is cer direc	To B	examiner? 1 ☐ Yes 2 X No	Hospital: 1 ☑ Inpatient 2 ☐ ER/O	Outpatient 3 DOA	Other		nce 6 □Other (Spe	ecify)
ding Ph h. After th tuneral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 28	c. Injury at Work?	28d. Describe ho		
Attendir death. ctor: Al y the tu	atle	2 Accident investigation		M	1 ☐ Yes 2 ☐ No			
r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, street, factory.	office	28f. Location (Str. City or Town	reet and Number or R. , State)	ural Route Number,
urs af								
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	Medical	29a. Certifier 1⊠ Certifying Ph (Check only one) 2 Medical Exam	rsician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurred at nd/or investigation, in	t the time, date and place n my opinion, death occi	e, and due to the ca arred at the time, da	tuse(s) and manner as ate and place, and due	s stated. e to the cause(s)
To th withir To th comp	M	29b. Signature and title of certifier	DESCRIPTION OF THE PROPERTY OF	29c.	License number	29	9d. Date signed (Mont	th, Day, Year)
10		+ PSALY COUD	Altendora		D42580		October	18, 2004
		30. Name and address of person who o		(Type, Print)		1		
		Parmjit S. Aujla		apolis Rd	., #13, Bla	densburg,	MD 20710	
Sta	ate rar	31. Date filed (Month, Day, Year) OCT 2 0 200	32. Registrar's Signature	Ka di				-

State of Maryland / Department of Health and Mental Hygiene 34988 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** John 1220 AM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia 8. Date of Birth (Month, Day, Year) HOWARD If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Birthplace (State or Foreign Country) 1**⊠**M 2□F Months 216-20-5404 77 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Exercises must be notified at MD Howard Yes 2 No Columbia Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 5021 Round Tower Place 238 21044 U.S.A. by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status filed within 72 hours after Almed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates: 46 - 74 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 ŏ 1 ☐ Yes 2 🛣 No Specify Black 3 ☐ Widowed 4 ☐ Divorced "nature!" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) U.S. Army (Retired) U.S. Government 12th I Pages 1 and 2 should be filed without of Health and Mental Hygien tent: if item 27 is marked other thinty or other traumatic event, I. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be John K. Lyles Saloma Preston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5021 Round Tower Pl, Columbia, MD 21044 Clister M. Lyles (Wife) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit Pages
Department of H
Importent: if ite
any injury or ot 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem 11/4/04 ' 4 ☐ Donation 5 ☐ Other (Specify) Ft. Myer, VA 21. Signature of Editeral Service Licer see 22. Name and Address of Facility SNOWDEN FUNERAL HOME, 246 N. Wash. St., Rockville, MD 20350 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heap failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sep tic Shac /Medical Due to (or as a consequence of): Examiner numanio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner physician and s the burial-transit The law requires that the death certificate be executed lante Due to (or as a consequence of): P.O. Box 68760. Physician/Medicai for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 si 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐ Yes 2√2 No Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred After Natural Accident 5 Pending investigation Injury after death. 1 ☐ Yes 2 ☐ No the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 811F3 000 -M 70 mD 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) 5755 Minney Ceder Columbia mo 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 20 2004 OCT Registrar

)4-6929		1- State Unpend Item Registrer	25tate7 ^f r	Maryla	n d:89 9 <i>Ce</i>	ntme rtifica	nt o4 He	ealth an Death	d Mental F	Hygier Reg. I	2004	34989
Physicia /Medic		1. Decedent's Name (First, Middle, Las	Debora	ah	LY	NCH			2. Date of Month OCTOB		Day Year 6, 2004	3. Time of Death 5:45a
Examin		4a. Facility Name (If not institution, give SHADY GROVE ADVENT		,			CKVII	Location of D			4c. County of Death	1
Funeral Director		5. Social Security Number 6. Se			s. last birthday) Yrs.		r 1 Year	If Under 24	Hrs. 8. Date of (Month, March	Dieth	0.00	pplace (State or Foreign intry) hington, DC
aryland show	_	Usual Residence of Decedent 10a. State 10b. County		10c. C	City, Town or Lo	ocation						10d. Inside City Limits
the M retifie	recto	Maryland Montgot 10e. Street and Number	mery		Po	toma	C p Code			10g. (Citizen of What Cou	1 ☐ Yes 2 ĀNo
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, the Marical Examiliant is a builling at once.	by Funeral Director	11. Marital Status 1 Never Married Married 3 Widowed 4 Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	es? ⊠No		Was Dece if Yes, spe 1 Yes		panic Origin , Mexican, P Specify:	? (Specify Yes or ruerto Rican, etc.)	No-	14. Race - Amer Black, White Specify: Wh:	, etc.
Maryland 21215-0036 at 2 should be filed within 72 hours affulls and Menial Hygiene. 27 is marked other than "natural", or traumatic event, it e Medical Exercit	Be Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-40	or 5+)	(Give	dent's Ust kind of w DO NOT t		ion Iring most of	working	16b.	Kind of Business/li Own Home	ndustry
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Baltimore, sermit. Pages 1 ar Department of Hea mportant: If item: iny inity or other note.		20a. Method of Disposition ¡X☐ Burial 2 ☐ Cremation 3 ☐ ' 4 ☐ Donation 5 ☐ Other (Specify		ite	Place of Dispo cemetery, crem	natory or	other place)	'	/28/04 en		Location - City or T	
Balti permit. Departin Importa any inju		21. Signalute of Funder I Service Licens	9 0	7					Funeral	Hom	e	20012
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W + 52	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcon 1□Live birth 4□Pregnant 9□Unknown	2 Feta	al death 3 [Ectopic p					23d. Date of delive Month	ery Day Year
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To tha within 2 To tha complet	Ž	29b. Signature and title of certifier	M			290	OCME				ate signed (Month, OBER 26,2	
		30. Name and address of person who co	empleted cause of	f death (Iter			n Str	reet. 1	Baltimon	e. Ma	aryland 2	1201
Stat Registra	3	31. Date filed (Month, Day, Year) OCT 2 9 200	32. Regis	strar's Signa			rels!					

		1	For State Registrar	State of Ma	aryland /	Depa Cer	artment of H	ealth and N Death	Mental Hyg هر	iene ()	04	34990
			Decedent's Name (First, Middle,						2. Date of Deat Month	h Day	Year	3. Time of Death
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	show		10a. State 10b. County	acmorii.			ersburg					1 XYes 2 No
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215-0036	d within 72 hours after death with the marylar speed. Then "natural", or Itams 23a or 28a-f show the Madical Examiner must be notified at	d by	3 AWidowed 4 Divorced	Year or Dates:						16b. Kind of	Vil	hite
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_	otha Ant,	BeC	17. Father's Name (First, Middle, La	ast)				18. Mother's Nam	ne (First, Middle, M	Maiden Sum	ame)	
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Maryland	2 sho and is mu		19a. informant's Name/Relationshi		1	19b. Mailir	ng Address (Street a	and Number or Ru. Crasant	ral Route Number • Ontar:	City or Tov	m, State, Z anad	a K2K 3E5
e)	1 and 1ealth am 27 ther to		Dung Nguyen - 20a. Method of Disposition	Son	20b. Place	e of Dispo	sition (Name of		4	20c. Locatio		
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89	eath certifica attending ph I for use as th	Physician/Medical	IF FEMALE:	00. 1/								
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of		2	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 V Inpati 28a. Date of Inju		VOutpatie	nt 3 DOA	4 Nursing n	ome 5 Reside			cify)
	ding h. After fune	tion	1 Natural 5 Pending 2 Accident investig	(Month, Da	ay Year)	Injury	Wor	k? Yes 2 □ No				
Division	or Attending after death. Diractor: After in by the fune	Certification:	3 Suicide 6 Could not determine	ot be 28e. Place of In	njury - At home	e, farm, st	reet, factory, office		28f. Location (Si City or Town	treet and Nu	mber or Ru	ral Route Number,
ă		Cert	4 🗆 Homicide	Building, e	tc. (Specify)				Oily or rom	r, 5tato)		
	To tha Hospitel or within 24 hours afte to tha Funaral Dir completely filled in	edicai		Physician: To the best examiner: On the basis of								
	To tha H within 24 To tha F complete	Medi	one)	and manner st	stated.		29c. Licens	e number	2	9d. Date sig	ned (Monti	h, Day, Year)
)	To To	-	29b. Signature and title of certifier	7		M	40	8681		-		, 2004
•	1		30. Name and address of person v	who completed cause of	death (Item 2)	3a) (Type	Brint)					
			Dr. Jude Ale	exander, M	ID 980	1 Me	edical C	enter D	rive Ro	ckvi	lle,	MD 20850
	St	ate	31. Date fill d Month, Day, Year)	32 Regist	trar's Signatur		Sporks					
	Regist	rar	OCT 212	004 Since	/	N	pyours					

ending physician and use as the burial-transit the attending physician Division of Vital Records, P.O. Box 68760 After this funeral

State of Maryland / Department of Health and Mental Hygiens 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day Year AMM /Medical october 20 2304 4a. Facility Name (If not institution, give street and number)
SHADY GROVE ADVENTIST 4b. City, Town, or Location of Death Examiner 4c. County of Death ROCKVILLE, MARYLAND MO

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)

OCT. 20, 2004 HOSPITAL MONTGOMERY 6. Sex 1 □ M 2 F 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign NONE Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location iem 27 is marked other than "natural", or items 23e or 28a-f show other traumatic event. Its Medical Examinar must be notified at 10d. Inside City Limits Director FREDERICK EDERICK, 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 2 any injury or other traumatic event, the Medical Evantians meet he space. 10g. Citizen of What Country? 1505 WOOD WAY Completed by Funeral USA Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates: 1 □ Yes 2 0 40 Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry econdary (0-12) College (1-4or 5+) INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be DEREK AMM 19a. Informant's Name/Relationship, (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or WOOD 20c. Location - City or Town, State MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 Cremation 3 P

4 Donation 5 Other (Specify) 3 Removal from State BALTIMORE, MARYLAND CYCLE NOV. 22,2004 22 Name and Address of Facility MEDICAL CENTER DRIVE, KOCKVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 M 30mun Immediate Cause (Final **Physician** AIR Leak disease or condition resulting in death) Syndrom /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MORETH e to (or as a consequence of): Examine Due to (or as a consequen of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No
9 Unknown 3 DEctopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 1 🗆 Yes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 - No the Hospitel or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ + 16 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Direc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RUST ma October 51461 30. Name d address of person who completed tause of death (Item 23a) (Type, Print ADVENTIST, 9901 MEDICAL CENTER DR. KOCKVILLE) HALLY GROVE 31. Date filed (Month, Day, Year) 32 Registrar's Signature 4 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State Amend Item 4a&28f per me G83926	artment of Health and Mental Hygiene 1 Arthread of Assertion Reg. No. 2. Date of Death	04 34992 3. Time of Death
1	Physic /Medi		Edward S. Macha	Month Day	Year 2:10a M
7	Exami		4a. F 8809 me (If not institution, give street and number) 8813—BLUE SMOKE DRIVE	4b. City, Town, or Location of Death 4c. Count	ty of Death
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 375-76-4811 1⊠ M 2□ F 36 Yrs.		O Bish-law (Out - F- /-
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I TX. Atascosa Poteet	ocation	10d. Inside City Limits 1∑Yes 2 □ No
	3a or 28a	Funeral Director	10e. Street and Number 325 Ashford Circle		What Country?
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be routiled at		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. I Yes 2 No II Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	ce - American Indian, ack, White, etc. fy: White
21215-0036	within 72 ho ene. than "natur ne Mcdical E	Completed by	(Specity only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	dent's Usual Occupation kind of work done during most of working DO NOT use retired) 16b. Kind of E	Business/Industry
	be filed tal Hygie d other event, II	Be C	17. Father's Name (First, Middle, Last)	arpenter Const 18. Mother's Name (First, Middle, Maiden Surma)	ruction me)
Maryland	2 should be filed with and Mental Hygiene. Is marked other that aumatic event, Ire.	TOE	Enrique Machado 19a. Informant's Name/Relationship (Type, Print) 19b. Mail	Maria De La Luz Sa	
e, Ma	l and 2 s lealth ar m 27 ls har trau		Tammy L.Ballance/Fiance 325	Ashford Circle, Poteet, T	exas 78065
Baltimore,	Pages I		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition Cemetery, cre Rambie	natory or other place)	-City or Town, State erset, Texas
Balt	permit. Pages 1 and 2 Department of Health at Important: if item 27 Is any injury or other trau		21. Signature of Funeral Service License	HTTP OSRTNÄLDI FUNERAL SER 241 Columbia Blvd.Silver Sp	RVICE, P.A.
Ī			23a. Part1. Enter the disease or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac or respiratory arrest,	Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	Chat	Onset and Death
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
68760,	ifficate be executed ig physician and as the burial-transit	edical Exar	that initiated events resulting in death) Last C. Due to (or as a consequence of): d.		
.O. Box	The law requires that the death certifics tto has been signed by the attending pt age 2 should be detached for use as t	Physician/Med		Ectopic pregnancy	te of delivery onth Day Year
Records, P	w requires that been signed I should be det	þ	Part II. Other significant conditions contributing to death but not resulting in the u		ribute to the cause of death?
al Reco		Completed		autopsy performed?	Were autopsy findings available prior to completion of cause of death?
Vital	Physiclan: this certific ral director,	o Be	25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	26. Place of Death (Check only one)	
οr		-	27 Manner of Death 29a Date of Jaines 20b Time	28c. Injury at 28d. Describe how injury occurr	er (Specify) ed
sioi	Attending or death. actor: After by the funer	catic	2 Accident investigation relea to 4	4 M 1 Yes 2 No Subject sto	Med
Division	To the Hospital or Attend within 24 hours after death To the Funaral Diractor: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str. building, etc. (Specify)	Orive gerthers have	2 Man land
	the Host in 24 ho the Funs pletely fi	ledical	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge, deat 2 ▼ Medicel Examiner: On the basis of examination and/or in and manner stated.	occurred at the time, date and place, and due to the cause(s) and me estigation, in my opinion, death occurred at the time, date and place, a	nner as stated. and due to the cause(s)
		Σ	29b. Signature and title of certifier		(Month, Day, Year)
	4		30. Name and address of person who completed caute of death (Item 23a) (Type,	OCME OCTOBER	11,2004
			THE DOORE MIKING 1	1 Penn Street, Baltimore, Maryl	and 21201
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Souls	

		•	1 - For State Registrar	State of N	laryland / Depa Ce	artment of F			giene Reg. No.	004	34993
	Physic /Medi		1. Decedent's Name (First, Middle, L MARGARET	T. MASO				2. Date of De Month	20 Day	Year 2004	3. Time of Death 8:32 A M
A S	Examir	ner	4a. Facility Name (If not institution, g John B. Parsor 5. Social Security Number 6.	s Home	r) Age (In yrs. last birthday)	4b. City, Town, o Salisbu If Under 1 Year	ry		Wi	unty of Death	
L	Funeral Director		213-22-8499 Usual Residence of Decedent	1 M 2 X F	77 Yrs.	Months Days	Hours Mi			9. Birthp Coun	lace (State or Foreign try) D
	a-f show	ctor	MD Worces	ster	10c. City, Town or Lo					1	0d. Inside City Limits 1 Yes 2 No
	th with the 23a or 28	al Director	309 Bay St.			10f. Zip Code 21863			10g. Citizen US	of What Coun	try?
980	within 72 hours after death with the Maryland ene. than "neturel", or itams 23a or 28a-1 show to Moulcal Exemple mast be restlibled	by Funeral	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	s?] No	Was Decedent of H If Yes, specify Cuba 1 Yes 280 No	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No arto Rican, etc.)		Race - Americ Black, White, o ecify: Whi	etc.
Maryland 21215-0036		Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4o	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	orking		ery Sto	
/land		To Be (17. Father's Name (First, Middle, Last Jesse M. Turner				18. Mother's N	ame <i>(First, Middl</i> e, Truitt	Maiden Sur	mame)	
_	alth and 25 is m		19a. Informant's Name/Relationship Lorenzo Mason (Bay St.					Code)
Baltimore,	permit. Pages 1 a Department of He Importent: If Itam any injury or othe		20a. Method of Disposition 1 🗶 Burial 2 □ Cremation 3 1 □ Donation 5 □ Other (Special Control of Control of Special Control of Special Control of Control of Special Control of Contr	ify)	Snow Hill Church	natory or other place	n 10- ss of Facility T	24-04 he Burba	Snow age Fu	uneral	aryland Home
	cate be executed /Medical Examiner ithe burial-transit	Ical Examiner	23a Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisass or hury that initiated events resulting in death) Last	b. Due to (or a	is a consequence of): s a consequence of):		g, such as cardi	ac or respiratory a	rest,		Approximate Interval Between Onset and Death
O. Box 6	requires that the death certificate is signed by the attending placed by detached for use as the detached for use as the contraction.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d.	Date of deliver Month	ry Day Year
J.	w requires that been signed by should be deta	by	Part II. Other significant conditions	contributing to death	but not resulting in the u	nderlying cause give	en in Part I,		obacco use d		e cause of death?
Vital Records,	The law ate has b page 2 s	Completed								b. Were autop prior to com death? 1 \(\text{Yes} \)	sy findings available ipletion of cause of
<u> </u>	95 G	o Be	25. Was case referred to medical examiner? 1 ☐ Yes ② No	Hospital: 1 ☐ Inpar	tient 2 ER/Outpatien	t 3 DOA Othe	20	eath <i>Check on o</i> Home 5 Resid		Other (Specify	
ion of	Attanding Phys r death. actor: After this by the funeral di	atlon: T	27. Manner of Death 1 X Natural 5 Pending 2 Accident investigati		jury 28b. Time of Injury	28c. Injury Work	at at	28d. Describe h			,
Division	tal or Attands after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine	200. Flace of I	njury - At home, farm, str etc. <i>(Specify)</i>	eet, factory, office		28f. Location (S City or Ton	Street and Nu m, State)	ımber or Rural	Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	edical (29a. Certifier 1 ★ Certifying F (Check only one) 2 → Medical Ext	Physicien: To the best miner: On the basis and manner s	it of my knowledge, death of examination and/or in- stated.	occurred at the tim restigation, in my op	ne, date and place pinion, death occ	ce, and due to the curred at the time,	cause(s) and date and plac	manner as sta ce, and due to	ited. the cause(s)
i	To the within 2 To tha complet	M	29b. Signature and title of certifier			29c. License	number		29d. Date sig	gned (Month, E	Pay, Year)
1	H.5		30. Name and address of person who	completed cause of	death (Item 23a) (Type.	Print)	Division	st. 54	LISBURY	WD	21804
	Sta Registi		31. Date filed (Month, Cay, Year) OCT 2 2	2004 32. Figis	trar's Signature	rade					

			1 _ For	State of Marylar	nd / Depa		of He	ealth and		ieren n	14 34	991.
			Registrar 1. Decedent's Name (First, Middle, Last))	Oei	inicate	010	Calli	2. Date of Dea	eg. No.	. 0 1	ime of Death
	Physici		. A . A	TTAX					Month	Day 24 2	Vana	:16 PM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)				ocation of Deat	h	4c. County		
			UNIV OF MARYLAN	O MEDICAL O	LENTER	BI	ALTI	MORE				
	Funeral		Social Security Number 6. Security Number	THE OFF		If Under	1 Year Days	If Under 24 Hrs Hours Min.		Yeer)	9. Birthplace (S Country)	State or Foreign
	Director		215-57-9621 Usual Residence of Decedent	1M 2AJF 4	Yrs.				March 4		Maryla	and
	land		10a. State 10b. County	10c. Ci	ty, Town or Loc	cation					10d. Ins	ide City Limits
	f sho	lor	Washingto		TTo moment	-0					1 [Yes 2 No
	r 28a	Director	Maryland Washingto		Hagerst	10f. Zip (Code		1	0g. Citizen of V	What Country?	
	h with	al D	13007 Orchid Drive	٩			2174	12		U.S.A.		
	deat	ner		12. Was Decedent Ever in U Armed Forces?	l.S. 13. V	Vas Decede			Specify Yes or No- to Rican, etc.)	14. Rac	e - American Indi	an,
9	or ite	by Funeral	Never Married 2☐ Married	1 ☐ Yes 2 ☐ No If Yes, Give		Yes 2		Specify:	to riican, etc.)		z: White	
21215-0036	within 72 hours after death with the Maryland ene. then 'netural', or items 23a or 28a-f show the Madical Exemiran must be molified at	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:								
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12	withly ene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5+)	1110. L	O NOT use	e rearea)					
	Hygi ther int, I		17. Father's Name (First, Middle, Last)				1	8. Mother's Na	me (First, Middle, I	Maiden Surnam	ne)	
an	ould be Mental larked o	To Be	Steven E. Mattax					Candy S	. Yeager	Mattax	:	
Maryland	2 should and Men le marke raumatic	_	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address			ural Route Number			
	Health a tem 27 le		Steven E. Mattax	(Father)	13007	7 Orch	nid D	rive Ha	gerstown	Maryla	nd 21742	2
J.e.	of He of He item		20a. Method of Disposition	20b.	Place of Dispos	sition (Name	e of her place)		Date	20c. Location -	City or Town, Sta	ate
E	Page nent c ant: If		1 X Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	emoval from State	se Hill		. ,		28 2004 1	Hagerst	own Mary	land
Baltimore,	permit. Pages 1 and 2 Department of Health s Importent: If item 27 li any injury or other tra		21. Signature of Funeral Service License	99	22.	Name and	Address	of Facility Do	nuglas A.	Fierv	Funeral	Home
<u>m</u>	\$0 E 8 8		Deugla &	Luy	13	331 Ea	aster	n Blvd.	ouglas A. N. Hage	rstown	Maryland	21742
			23a. Part1. Enter the disease, or compleshock, or hear failure. List only or	ications that caused the dea	th. Do not ente	r the mode	of dying,	such as cardia	c or respiratory arre	est,	Interv	ximate al Between
	Physician		Immediate Cause (Final disease or condition	LE	FUKE	MII	4				Onset	and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
	Examiner		Sequentially list conditions,)								
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):							
	ate be executed hysician and the burial-transit	хап	that initiated events resulting in death) Last	Due to (or as a consec	uence of):							
760,	be e	calE			, ,							
687	ficate phys s the			1								
Box (leath certificat attending phy I for use as th	/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn						23d. Dat	e of delivery	
B	death atter	ciar	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o		Ectopic pre Other (spe				Mo		Year
0	oy the	hysi	9 Unknown	9□Unknown								
σ,	The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as it	Completed by Physician/Med	Part II. Other significant conditions con	ntributing to death but not res	sulting in the un	derlying ca	use given	in Part I.	23e. Did tot	acco use conti	ribute to the caus	e of death?
ď	an sig	ed k	ANEMIA						1 □ Ye	s 2 00	3 Probably	4 Unknown
Records,	aw re is bec 2 sho	piet	COAGULOPATI	77					24a. Was a	n 24b. V	Vere autopsy find	
Ä	The lay	mo		·					autops perform	ned?	prior to completion death? □ Yes 2 □ No	
Vital	ysicien: The la is certificate has director, page 2	BeC	25. Was case referred to medical examiner?					26. Place of De	ath (Check only on	/		
of V	Attending Physicien: r death. ector: After this certifica by the funeral director, I	To	1 ☐ Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient	3 DOA	Other:	4 Nursing H	lome 5 Reside	nce 6 Othe	er (Specify)	
0	ding Phy h. After thi funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury a Work?	ıt	28d. Describe ho	w injury occurr	ed	
sio	Attendideath.	cati	2 Accident investigation 3 Suicide 6 Could not be		<u> </u>	М		s 2 No				
Division	or Ati after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, stre fy)	et, factory,	office		28f. Location (Sti City or Town	reet and Numbe , State)	er or Rural Route	Number,
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Ce	29a. Certifier 1X Certifying Physical Certification Physical Certi	pician: To the heet of my lim	awlades dash	000:	A Abre Att-	data and -1-	and due to the			
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	o the o the omple	Me	29b. Signature and title of Certifier			29c.	License r	number	29	ed. Date signed	1 (Month, Day, Ye	ear)
				PEDIAT	0:15	I	1	705	2	4		,
	14		30. Name and address of person who co			Print)	•				1	•
15	1-4		AYDIAY YANIY	22 S. GREEN		RA	LTIM	ORE, 1	ND 2121	01		
	Sta	-	31. Date filed (Month, Day, Year)	32. Registrar's Signa			,					
	Registr	ar	UG 26 20	104 Marcan	17. 19	MAL						

			State of Maryland / Department of Health and M	•	•
			1- For Registrar Certificate of Death	, 0	2004 34995
	Dhysisi		1. Decedent's Name (First, Middle, Last)	2. Date of Death Month	3. Time of Death
	Physici /Medic		Barbara Mrazik Moore	OCTOBER	
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death St. Mary 's Hospital Leonardtown	1	4c. County of Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	St. Mary s 9. Birthplace (State or Foreign Country)
	Director		192-20-2664 1 M 2 M F 77 Yrs. Months Days Hours Min.	(Month, Day,) April 1,	1927 Hungary
	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Manyl -f aho lied a	tor	Maryland St. Mary's Dameron		1 ☐ Yes 2 X No
	r 28e	Director	10e. Street and Number 10f. Zip Code	100	J. Citizen of What Country?
	23e c		17985 Three Notch Road Apt. #10 20628		U.S.A.
	er dea Itams	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
336	urs aft	by F	1 ☐ Never Married 1		Specify: White
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mantal Hygiene. Is marked other than "natural", or Itams 23e or 28e-f ahow aumatic avent, the Medical Evapting must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) [Second on the second	king 16	6b. Kind of Business/Industry
2	vithin ne. han "	mple	College (1-4015+)	Na ing	
d 2	filed v Hygie ther t	CO e	12 Home Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name	ne (First, Middle, Ma	Own Home
<u>a</u> n	d d d	To Be	Michael Mrazik Rose N		den Garrante)
ary	should and Men s marke umatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		City or Town, State, Zip Code)
Σ	and 2 salth a n 27 is		Thomas S. Moore / Husband 17985 Three Notch Road	Apt. #10	, Dameron, MD 20628
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Itam 27 is marke any injury or othar traumatic. once.		1 Burial 2 XX remation 3 Bemoval from State cametery, crematory or other place)		c. Location - City or Town, State
tim	rtmen rtent: njury		`4 Donation 5 Other (Specify) Brinsfield-Echols 10/28	8/2004	Charlotte Hall, MD
Ba	permit. Departr Importe any inju		21. Signeture of Funeral Sern Licensee 22. Name and Address of Facility B P.O. Box 279 Leona		Funeral Home, P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart future. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition		Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a consequence of):		
	Lammer	-	Sequentially list conditions, Due to: for as a conseque e of):	(X).	
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
o,	ate be executed hysician and he burial-transit		that initiated events ' c. resulting in death) Last		
3760,	ate be hysicia he bu	Ical	d		
x 68	The law requires that the death certifica Ite has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:		
E Box	attend for us	cian,	23b. Was decedent pregnant in the past 12 months? 1 Ves 2 December 2 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Pregnant at time of death 5 Other (specify)		23d. Date of delivery Month Day Year
MOORE, P.O. E	the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		
S, E	ss that gned b	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
ZIK	equire sen si		Lung Canainana.	1 ☐ Yes	2 No 3 Probably 4XXInknown
MRAZIK I	has b	Completed	0	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	10 02			performe 1 □ Yes 2 €	
BARBARA Division of Vital	/sicie/	o Be	Hospital:	h (Check only one)	e 6 □Other (Specify)
3AR	ig Phy ter thi	T:u	27, Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe how	
Sior	Attendir death. ctor: Af y the fur	ertification:	2 Accident investigation M 1 Yes 2 No		
O V	after d Diract Jin by	ırtifi	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, state)
	spital cours a narel l	O	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the caus	e(s) and manner as stated
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	edicai	(Check only one) Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated.	red at the time, date	and place, and due to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier 29c. License number	29d.	Date signed (Month, Day, Year)
			D60888		10/27/04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAKHI KRISHNAN SHAH ASSOC HOLLYWOOD MD 20636		
	Sta	te	24 Data filed (Month Park Visca)		
	Registr	_	OC 2 8 2004		

			State of Maryland / Dep 1 - State Registrar AMEND ITEM #5 PER INF G838 72	artment of Health and Mental Hygiene 004 34996
	Physici /Medic		Decedent's Name (First, Middle, Last) DEBORAH ANN MASON	2. Date of Death October 18, 2004 3. Time of Death 11:32 P M
	Examin		4a. Facility Name (If not institution, give street and number) Casey House	4b. City, Town, or Location of Death Rockville Montgomery
	Funeral Director		5. Sex 1. M 2. F 7. Age (In yrs. last birthday, 1. M 2. F 51 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 12, 1953 PA Page 15 PA PA PA PA PA PA PA P
	show	70	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L Md • Montgomery Germanto	- Way
	th the N or 28a-f	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
	eath w	eral	19601 White Saddle Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13.	20874 United States Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian,
036	ours after d ral', or Itan Exeminat	by	1. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never N	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1□ Yes 2☒ No Specify: 1□ Yes 2☒ No Specify: 1□ Yes 2☒ No Specify: 1□ Yes 2☒ No Specify:
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23s or 28s-f show aumatic event. If a Maxical Examinator ust be muffield at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 16a. Deceder(Give life) Admir	dent's Usual Occupation I fish of work done during most of working DO NOT use retired) Listrative Assistant Hughes Network Systems
land 2	0 = 0 5	To Be Co	17. Father's Name (First, Middle, Last) Steve Puto	18. Mother's Name (First, Middle, Maiden Sumame) Eleanor Blasco
Mary	12 shound Minary Is man	_		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Baltimore, 1	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic an		20a. Method of Disposition 1 Rurial 2 MCremation 3 Removal from State 20b. Place of Disposition 20c. Method of Disposition	position (Name of matory or other place) itan Crem. Date Oct. 19, Alexandria, Va.
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licensee 2	O East Deer Park Dr. Gaithersburg, Md. 20877
	Pnysician /Medical		23a. Part 1. End the disease, or complications that caused the death. Do not en shock, or feart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Metastatic Endome	Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c	
.O. Box 6	at the death certifica by the attending pt tached for use as t	Physician/Med		☐Ectopic pregnancy 23d. Date of delivery Month Day Year
_	s tha	by	Part II. Other significant conditions contributing to death but not resulting in the t	nderlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown
Records,	The law require ate has been sig page 2 should b	Completed		24a. Was an autopsy autopsy findings available prior to completion of cause of death? 1
Division of Vital	Attending Physician: The r death. sctor: After this certificate hiby the funeral director, page	To Be	25. Was case referred to medical examiner? 1	1
Divis		Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To tha Hospital or within 24 hours afte To tha Funaral Dii completely filled in	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the cause(s) and manner as stated. vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
•	To the within To the comple	×	29b. Signature and till abi certifier	29c. License number 29d. Date signed (Month, Day, Year)
	9		30. Name and address of person who completed cause of death (Item 23a) (Type, Dr. Charles Harrison M.D. 6001 Munc	Print) aster Mill Rd. Rockville, Md. 20855
	Sta Registi		31. Date filed (Month, Day, Year) OCT 20 2004 32. Registrar's Signature	Sparks

			1 - State of Maryland / Dep	eartment of Health and Nertificate of Death		ene 004	34997			
	Physic	ian	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death			
Z >	/Medi		Timothy Morley		October	17, 2004	4:45 ам			
1	Exami	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	ath			
			Montgomery General Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Olney) If Under 1 Year If Under 24 Hrs.	O Data of Birth	Montgomery				
	Funeral Director		578-09-5449 18 M 2 F 98 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(1906 9. B	irthplace (State or Foreign Country) Ireland			
	ס		Usual Residence of Decedent							
	ahow	_	10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits			
	8a-1:	ct		r Spring			1 ☐ Yes 2 ☑No			
	with II	ä	10e. Street and Number	10f. Zip Code	100	. Citizen of What	Country?			
	eath	erai	3701 International Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13	20906		USA				
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Heelth and Mental Hyglene. Importent: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any injury or other treumatic event, it a M. dical Exp. uinst must be notified at 2006.	by Funeral Director	1 Never Married 2 Married 3X Widowed 4 Divorced 1 Was Deceded to the India. 13 12. Was Deceded to the India. 13 13. Armed Forces? 1 1 Yes 2 No If Yes, Give WWII Year or Dates:	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☐ No Specify:	ecity Yes or No- Rican, etc.)	Specify: W				
2-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv.	edent's Usual Occupation	16	ib. Kind of Busines	s/Industry			
21	ithlu ithlu	npie	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)						
	led w lygier ly lygier lygier lygier lygier lygier lygier lygier lygier lygier			ectrician		U.S. Gove	ernment			
Maryland	ntal H	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)				
Z	hould d Me mark matic	2	Daniel Morley 19a. Informant's Name/Relationship (Type, Print) 19b. Mail		O'Neill	T 0	-			
Ma	nd 2 s lith an 27 is treu			ng Address (Street and Number or Rura						
6	r Hee		20a, Method of Disposition 20b. Placa of Disp	00 Heritage Hills		c. Location - City of				
e E	ages ent of ry or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Gate Of Content of the Content o			•	ing, Maryland			
Baltimore,	permit. I Depertm Importer any inju		21. Signature of Funeral Service Licensee	2 Name and Address of Facility rancis J. Collins DO University Blvd	Funeral H	Home Inc.				
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			-	Approximate			
	Physician		Immediate Cause (Final disease or condition ACUTO Case A	ro-Vascular	toer de	tur	Interval Between Onset and Death			
	/Medical		resulting in death) a. Due to (or as a consequence of):	10-100/00000						
	Examiner		Sequentially list conditions, b							
	be sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.							
_	and and I-tran	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):							
8760,	icate be executed physician and s the burial-transit	ia E	333 10 (51 20 2 35) 100 (20 35)							
687	ficate p phys	edicai	d							
Box	The law requires that the death certific tie has been signed by the attending p vage 2 should be detached for use as:	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	livery			
	the atte	icla	1 Yes 2 No 4 Pregnant at time of death 5	Ectopic pregnancy Other (specify)		Month	Day Year			
P.0	that the de ed by the detached	h/s	9 Unknown							
	lgned be de	by	Part II. Dther significant conditions contributing to death but not resulting in the	nderlying cause given in Part I.	23e. Did tobac	co use contribute t	o the cause of death?			
oro	w requir been si should i	ted	Hauer onser prayers 1	recupus	1 Tes	2 No 3 P	robably Unknown			
Records,	e law has b	Completed	Hypertension		24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of			
A F		S			1 Yes	d? death? No 1 ☐ Yes				
Vital	5 8 6	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)					
—	Phys r this rat di	T.	1 Yes 2 No Inpatient 2 ER/Outpatien 27 Manner of Death 28a. Date of Injury 28b. Time of		ne 5 Residence 28d. Describe how i		ecify)			
On	th. After funer	tion	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 Yes 2 No	dd. Describe riow i	rijury occurred				
Division	Attended of the option	Certification	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st.		28f. Location (Stree	t and Number or R	ural Route Number			
Ö	s effe	Sert	4 Homicide determined building, etc. (Specify)		City or Town, S	tate)				
	To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After toompletely filled in by the funeral	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deat 2 Medicaf Exeminer: On the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	and due to the cause ad at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)			
	To the comp	Ň	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Moni	th. Day, Year)			
}	15		Wilkman J. Ninala	0 45 285	0	ctober 1	7,2004			
=	. /		30. Name and address of person who completed cause of death (Item 23a), Type,	Bright # 113, Silv	1er sprine	g, Md	20901			
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	Soco Kal		,				
	Registr	ar	OCI 21 2004 /	MOCKEN						

			1 - For State Registrar		aryland	d / Depa	artmen rtificate	t of H e of L	ealth a	and M		Reg. No		34998	}
7	Physicia /Medic Examin	al	Decedent's Name (First, Middle, La John Alexander M A. Facility Name (If not institution, given the control of the co	Morrison			4b. City,	Town, or	Location of	of Death	2. Date of De Month Octobe	Da er 1		3. Time of Death 10:15A	V
	Funeral Director					ast birthday) 8 Yrs.	Rock If Under Months		If Under:	24 Hrs. Min.	8. Date of Bi (Month, Do 05/07/	rth	ontgome 9. Bi	ry nhplace (State or Foreig ountry) nnsylvania	gn
	ō	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgome	ery	10c. City	Town or Lo					037077	1)2(7 10	10d. Inside City Limit	
	ath with the 23a or 28a ust be notif	rai Director	10e. Street and Number 299 Hurley Avenu	1e			10f. Zip	50				U.	tizen of What C		
036	n 72 hours after death with the Maryland "neturel", or Items 23a or 28a-f show adical Examiner must be notified at	by Funerai	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Deced If Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Am Black, Whi Specify: W	te, etc.	
Maryland 21215-0036	within 72 ho ene. than "netur no wedical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		i+)	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	al Occupa rk done d se retired,	ation Juring most	t of worki	ing		ind of Business lvertis:		
ylandz	ould be filed Mental Hygi arked other atic event,	To Be Co	17. Father's Name (First, Middle, Las John Alexander M	Morrison	,				Imo	gene	(First, Middle Lloyd	a, Maider	Sumame)		
re, Mar	Health and tem 27 is mother traum		19a. Informant's Name/Relationship Jean M. Perry, 9 20a. Method of Disposition	Sister	20b. PI		First	Ave	nue,	Bayı		lew Y	or Town, State, York 11: ocation - City o	705	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Madical once.		1 ☐ Burial 2 ☒ Cremation 3 (4 ☐ Donation 5 ☐ Other (Spec	ify)		Linco	1n Cr 2. Name an	emat d Addres	ory	y Sir	nple Tr	ibut	e	, Maryland	
Ę	Physician		23a, Part1. Enter the disease, or cor shock, or heart failure. List onh Immediate Cause (Final disease or condition	mplications that caused y one cause on each line	t the death								e, Mary	71and 20852 Approximate Interval Between Onset and Death	
760,	/Medical Examiner the printing representation of the printing	Examiner	resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Pneumon Due to (or as c. Metasta Due to (or as	ia a consequ tic P a consequ	Prosta									
O. Box 6876	death certific e attending p ed for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ ∪nknown	d. Congest 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	of pregnar	ncy death 3	Failu Ectopic pr Other (sp	egnancy					23d. Date of de Month	livery Day Year	
۵.	The law requires that the ate has been signed by th page 2 should be detache	b	Pan II. Other significant conditions Diabetes	contributing to death b	ut not resu	Ilting in the u	ndertying ca	ause give	on in Part I.					o the cause of death?	'n
al Records,	: The law recate has bee	Completed									24a. Was auto perfe 1 \(\text{Yes}	psy ormed?	prior to death?	utopsy findings available completion of cause of s	le
Division of Vital	Attending Physicien: The st death. ector: After this certificate by the funeral director, pag	ation: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No 27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da		ER/Outpatier 28b. Time o Injury		8c. Injury Work	er: 4 X Nu	rsing Hor	n (Check only me 5 - Res 28d. Describe	idence	6 □Other (Sperry occurred	acify)	
Divis	Dir Dir	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place of Inj building, et	c. (Specify	') 					City or To	wn, State	9)	ural Route Number,	
	To the Hospital or within 24 hours affe To the Funerel Dir completely filled in	Medicai		Physician: To the best aminer: On the basis o and manner st	f examinat		vestigation,		oinion, dea			date and		e to the cause(s)	
!	V		30. Name and address of person who	o completed cause of o			Print)	D550.				Octo	ber 19,	2004	
	Sta Regist	ate rar	Attan Kasid, MD, 31. Date filed (Month, Day, Year) OCT 21 20	32. Registr				ille		ylar	ıd				-

		1 - For Stata Registrar	State of M	laryland		artment rtificate			and M		Reg. No.	. U U	4	349	199
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Leader) Chester 4a. Fecility Name (If not institution, game of the compett and Week)	James)	Moats	4b. City, T		Location of	of Death	2. Date of De Month Octobe	r 22	200	Death	3. Time of 6:58	Death P
Funeral Director				ge (In yrs. las	t birthday) Yrs.	If Under 1		If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da 03/20/				lace (State o	r Forei
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is merked other then "natural", or Iteme 23a or 28a-f ehow other treumatic event, Itte Medical Expressional be notified at	Funeral Director	10a. State 10b. County WV Presto 10e. Street and Number Rt. 1 (PO Bo)		Eglor		10f. Zip 0					10g. Citi:	zen of Wha		od. Inside Ci 1 ☐ Yes try?	
ours after death	by	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent	?		Was Deceder f Yes, specifi			gin? (Spe , Puerto i	ecify Yes or No Rican, etc.))-	14. Race -	White,	etc.	
filed within 72 h Hygiene. Afher then *netu	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12) 4 17. Father's Name (First, Middle, La	rade completed) College (1-4or		(Give life.	dent's Usual kind of work DO NOT use	done di retired)	uring mos		ng (First, Middle,	Timl	nd of Busin		,	
should be fand Mental Is marked of	To Be	Joe Moats 19a. Informant's Name/Relationship			19b. Mailir	g Address (Rebe	ecca	Ship Mo	oats		ate, Zip	Code)	
8,2 = 5		Geraldine Moats 20a. Method of Disposition 1⊠Burial 2 □ Cremation 3 `4□Donation 5 □ Other (Spec		' [e of Dispo etery, crer	ox 45 sition (Name natory or oth Ridge	of er place)	D	26716-0 late 24/04 1	20c. Lo	cation - Cit			
permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Lice 23a. Pent1. Enter the disease, or co	2000		22 C	Name and hapel,	Address	of Facility wlesh	y Bro ourg,	wning] WV	Funeı		ome :	Burk	
te be ysicia ne bur	dicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last	b	cerebro a consequent a consequent a consequen	nce of):	ular a	eci	dent						Approximate Interval Betwood Service and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Conset and Cons	
The law requires that the death certifica see has been signed by the attending phoage 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic preg					2	3d. Date of Month		•	'ear
w requires that been signed should be de	ted by P	Part II. Other significant conditions	contributing to death t	out not resultin	ng in the ur	iderlying cau	se giver	n in Part I.						e cause of de	
	Completed	atrial fibrilla	ion							1 ☐ Yes	rmed? 2 XNo	prior deat	r to com	sy findings a pletion of ca 2 No	ıvaila ıuse (
Attending Physician: 1 r death. ector: After this certifical by the funeral director, p	Certification; To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending investigati 2 Accident investigati 3 Suicide 6 Could not	28a. Date of Inju (Month, Da		b. Time of Injury	28d	Other	4.X Nu≀	rsing Hom 2 No	(Check only one 5 ☐ Reside 8d. Describe has 18f. Location (S	dence 6 now injury	occurred			hor
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		4 Homicide determine 29a. Certifier 1 Certifying F	building, e	of my knowle	dge, death	occurred at	the time	e, date and	1 place, a	City or Tow	n, State)	and manne	ar as sta	ted	
To the Howithin 24 within 24 To the Figure Complete	Medical	29b. Signature and title of certifier 30. Name and address of person who	Manual Manual States of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Completed Cause of Cause Ca	ated.	M	29c. l		number	occurre	2	29d. Date	signed (M	fonth, D	ay, Year)	
Sta Registra		Walter K. Naumar 31. Date filed (Month, Day, Year) OCT 2 5	nn M.D., PO		247,		nt N	4D 21	520	-					

			1 - For State of Maryland / Dep Ce	artment of Health and Nertificate of Death		iene g. N2 0 () 4	35000
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Deat Month		Year	3. Time of Death
	/Media	cal	ESTHER E. MIZELL		OCTOBER	16, 200)4	7:25 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number) Heritage Harbour Health Center	4b. City, Town, or Location of Death Annapolis		4c. County of		dol
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs.	8. Date of Birth			ace (State or Foreign
	Director		579–24–5875 ^{1□ M 2} ▼ 82 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 10-1-1	922	Mary	zland
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L.	ocation			10	Od. Inside City Limits
	Mary	tor	Maryland Anne Arundel Ar	nnapolis				1 ☐ Yes 2 X No
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of W	hat Count	ry?
	s 23e	rall	1914 Marconi Circle	21401		USA		
	item:	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- America , White, e	
920	urs af	by		1 ☐ Yes 2X No Specify:		Specify:	Whit	æ
2-0	filed within 72 hours after death with the Maryland Hygiene. Uther then "natural", or Items 23a or 28e-f show ont, if a Medical Experiment near the natified at	Completed by	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation a kind of work done during most of work	ina 1	6b. Kind of Bus	iness/Indi	ustry
121	within ne. .hen "	mpl	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	,,,9			
d 2	Hygie Hygie other	ပိ	4 years 17. Father's Name (First, Middle, Last)	Ceacher 18. Mother's Name	e (First, Middle, M		ducat	ion_
Maryland 21215-0036	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heath and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28e-f show or other traumetic event. If a Madical Examinar marker nutilised at	To Be	Russell Mizell		lanche We		,	
ary	2 shou and N is mai			ng Address (Street and Number or Rura			tate, Zip (Code)
	and 2 ealth m 27 i			Schooner Circle Ar		MD 21	401	
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once.		I Duriai 2 Cremation 3 Hemoval from State	matory or other place)		Oc. Location - C		
Ē	artmer ortant: injury			Crematory 10-19		Edgewat	ter,	MD
B	permi Depa Impo any ir		> Ill Illee 20	2. Name and Address of Facility Geo 1973 Solomons Island	rge P. K.	alas Fu	neral	Home
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	st,		Approximate
ä	Pnysician		Immediate Cause (Final disease or condition	andin LH	-		_ (Interval Between Onset and Death
	/Medical Examiner		resulting in death) Due to (or as a const ue) to of):	9 7	700.1	1	7	m 97
	Laminer	<u>_</u>	Sequentially list conditions, b. Chronic lieu	o majpien	V		10	very you
	uted I Insit	Examiner	ause. Enter Underlying Cause, Disease or injury	an i	1		1	no Gra
o Î	exectan and and rial-tra	Еха	that initiated events resulting in death) Last C. Due o (or as a consequence of):					111
8760	death certificate be executed e attending physician and id for use as the burial-transit	dical	d. Theme.				L	m ym
9	ertifica ding pl	/Med	IF FEMALE:	Trich				•
Вох	eath certifi attending I I for use as	Physician/Me	The past 12 months:	□Ectopic pregnancy □ Other (specify)		23d. Date Monti	,	/ Pay Year
o.	at the de by the a tached	yslo	1 Yes 2 Mo 9 Unknown 4 Pregnant at time of death 5 L			ŀ		•
S, D	The law requires that the tee has been signed by the bage 2 should be detached.	by Pi	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contrib	ute to the	cause of death?
ğ	w requires that been signed k should be det				1 ☐ Yes	2 No 3	Probab	oly 4 □Unknown
Record	e law r has be je 2 sh	Completed			24a. Was an autopsy	24b. We	ere autops	y findings available of
		Con			performe	ad? de:	ath? Yes 2	
Vital	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? Hospital: Ho	26. Place of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		-	
o	ig Phys ter this neral di	H 1	1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury. 28b. Time of	28c. Injury at 2	ne 5 Residen 28d. Describe how			
Division	or Attending P after death. I Director: After I in by the funera	ertification:	1 Dending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
N N	r Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number State)	or Rural P	Route Number,
	oital o	0						
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Atter completely filled in by the funeral	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death of the basis of examination and/or in and manner stated.	n occurred at the time, date and place, a vestigation, in my opinion, death occurre	ind due to the cau ad at the time, date	se(s) and mann and place, and	er as stated due to the	ed. ne cause(s)
	To the within To the Comple	Me	29b. Signature and title of certifier	29c. License number	290	. Date signed (Month, Da	y, Year)
) 000 ×	D40519	1	0 - 1	8 -	.04
			30 Name and address of person who completed cause of death (Item 23a) (Type,	Print) A OO A	0 (0 1	Date signed () O - 1 Crit		
			31. Date file (Month, Day, Year) 32 Reg rar's Signature	ryton (redica	t conse	, ont	100	
ş	Sta Registra		31. Date file (Month, Day, Year) OCT 1 9 2004	South		·		